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ABSTRACT

The ad hoc network of shelters and related services that has been developed in an effort to meet the most critical needs of the homeless population is staffed by a wide spectrum of professionals and volunteers. Many of these individuals lack easy access to information, training, or resource materials to help them with their social services work. This handbook presents basic information and procedures to work effectively with homeless people. The primary audience for the book is the volunteers and staff who serve in private shelters and programs throughout the New York metropolitan area. Issues in the following areas are discussed: (1) working with homeless people; (2) homeless families; (3) mental illness among homeless people; (4) alcoholism and substance abuse; (5) health care; (6) preventing and managing conflict; (7) advocacy; (8) entitlements; and (9) shelter admission. Illustrations accompany the text. A short bibliography of additional resources is included. (BJV)

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WORKING WITH HOMELESS PEOPLE

A Guide for Staff and Volunteers

Columbia University Community Services
Amy Haus, Editor

Revised June 1988

This project was made possible through the support of the New York State Department of Social Services, Cesar A. Perales, Commissioner. Additional support was provided by Columbia University.

Illustrations by John Jenkins, a free-lance artist working in New York City, whose experience as a homeless man in the shelter system provided the basis for these drawings.

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Preface

The problem of homelessness is a profound and growing one in our nation. Perhaps nowhere is the problem more extreme or visible than in New York City. Voluntary and religious organizations have responded with an outpouring of assistance, augmenting the programs of local and state governments. These organizations provide food, temporary shelter, and other assistance to homeless people. Many are staffed by volunteers who donate their time.

The volunteers come from various walks of life; most have never before been involved in social service efforts, and few have prior experience assisting homeless people. Understandably, volunteers sometimes feel overwhelmed by the problems and needs of the homeless, especially those needs that go beyond the provision of temporary shelter and human comfort. Eager to help but unsure as to how they might do so, participants in such efforts often need orientation, training, and ongoing assistance to enable them to effectively aid the homeless persons who are guests in their programs.

This handbook was developed in response to that need. It presents basic knowledge and procedures that are effective in working with homeless people. The primary audience for the book is the volunteers and staff who serve in private shelters and meal programs throughout the New York metropolitan area. The substance of the book was developed by Columbia University Community Services (CUCS) during the process of conducting training for volunteers, staff, and coordinators of private shelters and meal programs in New York City and Westchester County over the last several years. CUCS has incorporated and drawn extensively upon the experience, knowledge, and skills of training participants in the development of its curriculum. This handbook, based upon the training curriculum, is intended to present that knowledge to a wider audience.

CUCS is funded by the New York State Department of Social Services, the New York City Department of Mental Health, Mental Retardation and Alcoholism Services, and Columbia University. Its purpose is to develop capable professionals committed to working with homeless people through its provision of direct services, training, curriculum development, and research endeavors. Administered by the School of Social Work, this interdisciplinary project draws on the collective expertise of faculty from Columbia's Schools of Architecture, Planning, and Preservation, Dental and Oral Surgery, Law, Medicine, Nursing, Public Health, and Social Work. Since its founding in 1980, CUCS has trained over 150 graduate students, hundreds of volunteers and paid

staff, and provided direct services to many of New York's homeless people.

This handbook reflects the work of many people. Foremost among the contributors have been Amy Haus, who compiled and edited the work, and Daniel Herman, CUCS Director of Training and Research, who oversaw the project from its start to its completion. Mona Bergenfeld, Julie Bramnick, and Tony Hannigan also contributed to its organizing, writing, and editing. Members of the CUCS service staff also contributed to the completed product. Among others, Tina Blake-Steele, Barbara DiCicco-Bloom, Suzanne Smith-Weiss, Andrea White, Alice Spears, and Ezra Susser were most helpful.

Much of the information in the handbook is based on a training curriculum developed by the staff of CUCS over the last several years. Douglas Dornan, Dorothy Faustino, Helene Fishman, Suzannah Gross, Etha Henry, and Monica Murphy, among others, were involved in that effort.

Many volunteers and professionals reviewed drafts and offered their time, expertise, and insight. Among those to be thanked are Rose Anello, Pat Burton-Eadie, Susan Carlton, Kristin Conklin, Colleen McDonald, Tillie Shuster, and Maria Vandor. We also thank Ned Walsh for word-processing, Geraldine Ivins for editorial guidance, and Janet Huet for technical advice and support.

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Introduction

The *ad hoc* network of shelters and related services that has been developed in an effort to meet the most critical needs of the homeless population is staffed by a wide spectrum of professionals and volunteers. Many of these individuals lack easy access to information, training, or resource materials to help them with their work in this challenging domain of social services.

The purpose of this guide is to furnish this information in an easily usable format that will be useful to those who are assisting homeless people. Material is presented at an introductory level; the guide assumes no prior background or experience in human services. Readers should recognize that the information contained in this guide, particularly the sections dealing with mental illness, substance abuse, and medical care, cannot substitute for the specialized training or experience needed to develop true expertise in these difficult areas.

We are aware of the inherent obstacles to providing services effectively to people who remain without permanent stable accommodations. We strongly believe that shelter and emergency services, while necessary, should not be viewed as long-term solutions to the problem of homelessness. Such solutions must address the fundamental causes of homelessness which, by now, are well known: a chronic low-income housing shortage; increasing numbers of impoverished and unemployed Americans; massive federal cutbacks in housing, income support, and social service programs; and inadequate community care for the seriously mentally ill.

Questions concerning the relative importance and interaction of these factors, how the problem has been allowed to escalate to such crisis proportions, and the relative merits of alternative strategies for redress are critical. Their exploration, however, transcends the scope of this book. Studies and reports that deal with these issues are listed in the Appendix. We urge the reader to use these resources in an effort to better understand the problem and guide his or her actions.

Chapter 1

Working With Homeless People

I feel like a refugee from America.
—elderly women's shelter resident

At their best, shelters are only a marginal response to the multifaceted problem of homelessness. Most homeless people coming to a temporary shelter experience some degree of distress and need in one or more aspects of their lives. Shelter volunteers understandably hope to be of real assistance to these people. Given the inherent limitations of a temporary shelter program, however, the volunteer frequently experiences a significant gap between what he or she would ideally hope to accomplish for the homeless person and what realistically can be achieved. It is easy for volunteers to slip into frustration, outrage, or sadness when confronted with overwhelming needs on the one hand and limitations in their ability to be of help on the other.

It is very important to recognize and remember that for most temporary shelters the optimal goals are providing *physical shelter, food, clothing, safety, personal comfort, and a caring person to talk to.* This chapter, designed especially for volunteers beginning to work in an overnight shelter program, addresses the basic skills you can use in pursuit of these goals.

ABOUT YOUR SHELTER

Shelter programs differ considerably in structure, philosophy, staff, and their capacity to provide for guests. Typically, shelters either have municipal sponsorship (city-run and staffed) or are privately sponsored (run by volunteers or non-profit agencies). Some programs have features of both. Some shelters operate all day; others only at night. Some accept walk-in clients from the street (direct intake) and others accept guests referred by other programs only, or work exclusively with special groups, such as women with children. There are shelters that have very limited roles for volunteers and others run entirely by volunteers.

In New York City, many of the overnight shelters staffed by volunteers from churches and synagogues have been organized by the Partnership for the Homeless (212-684-3444). This handbook is written primarily for volunteers and staff in this kind of program. The skills and techniques presented, however, will also be useful in other types of shelters and in other communities.

The format for programs sponsored by the Partnership for the Homeless is that of a religious or community organization providing space in its facility for a small shelter. Volunteers stay overnight with the guests. The City's Human Resources Administration (HRA) provides anywhere from six to nineteen beds, clean bed sheets, towels, and blankets for the shelter. A "screening site," usually a day program drop-in center, assigns guests to participating shelters on a nightly basis. HRA schedules and transports guests from the screening site to shelters in vans, and takes them back again in the morning.

The screening site is generally a day program that provides meals and other services for the guests. It is very helpful to learn about the particular screening site sending guests to your shelter. Knowledge of what it can and cannot provide, whether caseworkers or medical professionals are working with the guests, and its rules and regulations is valuable information. Caseworkers are staff members who work with individual guests to assist with housing, financial, and other service needs. Social workers may perform similar duties but the term "social worker" usually applies to a person with a master's degree in social work.

The shelter coordinator is the volunteer's immediate supervisor and is the liaison between agencies and among volunteers. He or she is the first person volunteers contact to answer questions or to relay information to the screening site. The coordinator and the staff at the screening site need to be kept informed about shelter operations, thus the more you know about various components of the shelter, the better for everyone.

WHAT VOLUNTEERS CAN PROVIDE FOR SHELTER GUESTS

The Basics: You will learn all the specifics of finding clean sheets, boiling water for coffee, and making sure guests sign in or follow whatever procedure the program has devised to provide food and shelter. This is the primary function of the shelter, and you should develop a full understanding of the routine and expectations.

Functioning as a Helper: Volunteers, working in conjunction with shelter staff, caseworkers, and other social service agencies' staffs, can help guests greatly by assisting them with their decisions regarding problems such as where to look for services and how to protect their rights and entitlements.

Companionship, and More: Shelters and shelter staff are a source of hope. They can provide a context for the restoration of the human spirit when hope has been lost.

WHY ARE YOU VOLUNTEERING?

In order to bring your best to the task of helping other people during a difficult time in their lives, it is worthwhile to review your foundation: Why are you doing this, and what do you expect to see as a result?

When you first explored volunteer work at your shelter, you probably filled out a questionnaire stating your reasons for wanting to become involved. The answer seemed obvious: Who wouldn't want to help with the tragedy of homelessness? Yet stopping to examine personal motivations and beliefs may reveal a wide range of responses.

Consider some of the following:

> "Working in a shelter is a kind of daring thing for me to do, considering my background. It will make me a more interesting person . . . I've never really talked to an actual homeless person and I'm curious."
>
> "I am angry with the government, organized religion, and my own community for not doing their part. I feel I have to do mine. I deserve no thanks. It's my duty."
>
> "Volunteering is a wonderful thing! To give to a poor, needy person and to see their gratitude. It must be very rewarding."

"Since I retired I needed something to do, so I called a volunteer organization. They recommended the shelter. Now I find such satisfaction working in the community and being part of a change for the better."

"I feel I could be homeless one day—it might happen to anyone. So I'm doing what I can now and hoping someone will be there for me if I ever need it."

"I'm not one of those selfish and competitive New Yorkers who only wants to make money and doesn't care about human beings. I'm different. I care about others."

"I feel so guilty when I see those tattered people on the street. I don't know if giving them money helps, so I thought shelter work might be a more substantial way to contribute."

Of course there are no right or wrong reasons for wanting to help, but these quotations reflect a range of motives, thoughts, and emotions that can affect a volunteer's interactions with both guests and co-workers in the shelter. Volunteers' sentiments typically include, among other things, anger, guilt, and a need for self-fulfillment. Most include genuine concern and a need to make the world a better place. Homelessness is a topic that elicits particularly strong emotions in most of us.

Volunteers will probably encounter co-workers whose philosophy and approaches to shelter work differ sharply from their own. Remember, no matter what the initial motivation, every volunteer did take an important step forward to help people who are homeless. It is not necessary for people to agree on all aspects of a problem in order to cooperate in working toward its resolutions.

The volunteer is both helper and learner, approaching a new job through trial and error, practicing through involvement, and making personal discoveries along the way. New volunteers do not need any particular skill or background to become effective shelter workers—open-mindedness and the desire to help will carry you a long way in this work.

COMMON WORRIES ABOUT WORKING IN A SHELTER

Apprehensions are natural when beginning shelter work. Some of the worries new volunteers may share are discussed briefly below.

Fear of Making a Mistake

Most volunteers start out inexperienced and slowly build familiarity and expertise. A new volunteer should expect to be put into a learning situation and

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feel comfortable *not* being an expert. When a mistake is made, acknowledge it yourself (and to the guest, co-worker, or whoever might be affected) and think of it as an opportunity to learn: "I'm sorry you were upset because I mixed up bed assignments. I didn't know that you always get the corner bed, but I should be able to remember from now on. You might want to remind me next time so I don't make another mistake, okay?"

Not Knowing What to do in an Emergency

The shelter should provide a protocol for what to do in an emergency that specifies the person to notify, such as the coordinator or building management. Volunteers needn't feel they are solely responsible for shelter operation, even though they may be the front line when anything happens in the shelter. If emergency procedures have not been specified by the shelter coordinator, ask enough questions to know what is expected of you.

Fear of Catching Something

The medical chapter in this book provides information about the nature of and the risk of catching communicable diseases. You may want to ask the coordinator about the shelter's policy on showers and the provision of clothing to prevent the spread of lice. In general, however, the incidence of volunteers "catching" anything at shelters is very, very low.

Strangeness

Most people are troubled by—and sometimes fascinated by—unfamiliar looks, behavior, speech, or lifestyles. A wide difference in lifestyles will most likely exist between you and the guest since most volunteers have never been homeless and usually live a middle- or upper-middle-class existence. It is not necessary to bridge the gap in order to assist the guest. It is important to reduce your anxieties or uncomfortable feelings that may be a hindrance to relating effectively with guests. Time, practice, and familiarity will alleviate most initial fears. As you become familiar with the new people at your shelter, you will soon find common interests that begin making the guests seem much less different from you.

In general, shelter guests don't want to cause fright or call negative attention to themselves. A peaceful night's rest is their primary need and what you can help to provide.

What's it like? Living in a shelter?
You'd never really know unless you've been there.
—homeless woman

Fear of a Specific Guest

First and foremost, it is important to trust your feelings as an information gauge about a person or situation. Explore what it is that is triggering these feelings. You needn't let the guest(s) know your level of fear while you are assessing the situation, but talking with other workers and staff will be helpful. Often fear of a particular guest simply dissolves as the guest and volunteer get to know each other. When fears persist, specifically fear of violence, do not hesitate to talk to the coordinator. Protocols, such as using a buddy system, making sure a telephone is near the sleeping area, and relying on the screening site will be helpful to review.

Saying "No"

One of the most difficult aspects of working with homeless people is that despite our wish to provide as much as we can to these people who have overwhelming needs, we often are in the difficult position of having to say "no." For example, a guest may not want to leave the shelter in the morning, for logical and obvious reasons. You will not feel good about saying "no," but you are not authorized to let him or her stay, either. You will need to say "no," and to understand that it is necessary at times. Enlist the support of your shelter coordinator and/or other volunteers if this is difficult for you. Be sure to learn the shelter rules, which you may be called upon to clarify for guests and co-workers. It is important to understand the reasoning behind policies and rules of the shelter.

Uncertainty About Your Role

Volunteers can perform a number of roles in the shelter, and it is necessary to get a clear idea of what is expected in each individual program. A volunteer

might wonder, "Am I suppose to be a disciplinarian? a guard? a cook? a waiter? a junior psychiatrist? a buddy and pal?" All of these roles require different skills, and you may not be sure what you will be expected to do. In addition, programs differ in their design of volunteer roles.

Volunteer activities are often affected by whether staff and paid professionals are employed to work with guests. Where such staff are available they may be helpful in explaining how responsibilities should be separated or shared. Even without paid staff on site, programs usually establish access to outside professional advice. In any case, if you are unclear about what is expected or uncomfortable about what your role implies, it is always wise to explore such issues with the volunteer coordinator until satisfaction is reached.

APPROACHING A GUEST

It may sound simple and too obvious to state, but—*the same rules of courtesy and conduct used among friends and acquaintances are appropriate with shelter guests as well.* One of the most emotionally damaging aspects of homelessness is the lack of respect experienced by homeless people in their dealings with individuals and institutions. Sometimes it is deliberate. Often it is automatic, however, and unrecognized as such.

A volunteer, for example, might assume that everyone in the shelter is to be addressed by his or her first name after being introduced initially in this manner. Yet this may not be acceptable to some guests, and can possibly cause bad feelings. Following rules of common courtesy will help you to discover people's preferences and to act in ways that show respect for them.

Here are some general suggestions for a new volunteer approaching a guest:

- Introduce yourself and let the guest know your role: "I'm Diane. I'm a new volunteer."
- Be aware that while some guests are "regulars" and know their way around, others may be in need of a tour or an explanation about the program. Find out who's a newcomer and offer to orient that person. It is sometimes difficult for a part-time volunteer to become familiar with the changing group of guests, so ask who needs information about the program.
- Offer to help any person who has pressing needs: "There's hot coffee over here and sandwiches if you'd like some." Out of consideration for the guest, avoid putting him or her in a position requiring a response if the guest does not want to talk to you.

- Let the guest warm up to you at his or her own pace. If guests seem to want quiet time alone instead of conversation, let them have just that.
- Take care to avoid excessive questioning, especially in shelters that do not see their role as part of the social service system. In voluntary shelters, the guest's personal history is only important if it pertains to immediate needs. Homeless people are frequently questioned in clinics, welfare offices, and in some cases, by researchers and reporters. A volunteer who provides a peaceful, unobtrusive presence may be doing far more for the guest than he or she imagines.
- Avoid talking to others about a guest as if he or she weren't there. This often happens when a volunteer is speaking on the guest's behalf to a professional. No one like to be ignored, especially if one is the subject of the conversation.
- Look at the person to whom you are talking, and give him or her your full attention. We all have experienced the irritation of trying to talk to someone, perhaps in a bank or in a job interview, who continues writing something unrelated to the conversation or who barely looks up from the desk. Try to meet at eye level, rather than hovering over a seated person, or leaving a standing person at the side of a desk.

A HELPING RELATIONSHIP

Depending upon the specific program, its goals, and the volunteer's duties, there is often the potential for a volunteer to develop a relationship with guests that they will find helpful in managing their lives. The "helping relationship" is one the volunteer consciously attempts to structure in ways that are responsive to the guest's needs. The forms such assistance can take will understandably be modest. Temporary shelters are not intended to replace social service organizations. On the other hand, you may find that through the development of a helping relationship you are in a position of assisting guests to clarify and organize life issues. You may be able to help a guest to take action on problems such as health or employment needs, or even to obtain benefits, like public assistance. Before initiating specific plans with a guest, discuss these plans with the coordinator.

Building a Helping Relationship

As you begin to engage in a helper role with a guest you may have difficulty accepting the guest's assessment of his or her priorities. The guest's goal or plan of action may seem all wrong—and, unwittingly, you may force your views

on the guest. When this happens, some guests will just go along with these views, perhaps for fear that if they do not, they will be evicted from the shelter. Others may not even realize that what you want is not what they feel. Still others will actively resist.

In any case, this is not the most effective way of helping the guest. The main drawback to this approach is that it rarely works—at least for long. Much time and effort can be wasted in trying to achieve your goals, and unfortunately, the guest does not follow through because he or she is not really committed to the effort. You might think: "After all this time and energy I invested, this is how you repay me?" The guest might say, "I never wanted any part of this. I wasn't deliberately deceitful—you just never listened." In such cases your actions are often experienced as patronizing. They can result in making the guest feel that his or her opinion doesn't really count very much.

Nevertheless, this situation occurs often and causes much frustration between shelter workers and guests. Remember—a relationship built on trust and respect is the basis for helping another person to get through a difficult and potentially demoralizing set of circumstances. A discussion of the skills volunteers can use to sharpen their abilities as helpers follows.

BEING AN EFFECTIVE HELPER

Building Trust

Trust evolves as a natural dimension of most human relationships. Many of us may have given little thought to the process of its development. For homeless people, who typically lead lives that have been characterized by let-downs and disappointments, trust is a very important issue. The essence of trust is that *one can be counted upon to honor commitments.* We trust those whom we perceive to be consistent between what they say and do. This definition of trust, therefore, suggests that one should not promise more than he or she can deliver. While you may be tempted to heighten a guest's spirits by promising to assist somehow in a difficult situation, you may have difficulty in delivering and are courting guest disappointment and distrust. Trust is also enhanced by follow-through. Whatever you commit to do—be it as simple as making a phone call for a guest or asking her how she is feeling in the morning—it is important to accomplish.

Trust is also engendered by communicating the feeling that one accepts the guest as he or she is. Homeless people have the experience of continuously being judged by the larger world. When a guest feels that you are not passing judgment, he or she will feel more trusting.

Trust is enhanced by the communication of concern. As a homeless person begins to feel that you are genuinely concerned for his or her welfare, the feeling of trust will grow.

Finally, trust is usually strengthened with honesty. If the guest asks your opinion on an issue over which you know you will differ, it is wise to be honest. If asked, for example, you might tell a guest you feel the guest's drinking is unhealthy, or that his choice not to seek permanent residence is unfortunate. We attempt to distinguish here between a volunteer's unsolicited showering of judgments on the guest, which will be destructive to the development of trust, and the honest communication of sentiment or belief to the guest when it is sought.

While building trust is extremely important in helping relationships, a sensitive shelter volunteer will also accept a guest's level of willingness or unwillingness to trust him or her. A homeless person may have legitimate reservations about being too open and trusting with a new person. The guest may simply need more time to develop trust than you think necessary. In these cases, respect the guest's boundaries and pattern of relating. A blend of mutual trust and respect is the ideal basis for a helping relationship.

Listening

Listening means not just taking in the facts and information but also attempting to understand their meaning for the guest. Try to hear what the story *means* to the person, along with the expressed and unexpressed emotions behind it. This requires full concentration and taking care not to tune out what is being said because of one's own thoughts interfering. We all know what it's like to have our thoughts drift off the subject when someone is speaking. In addition, we sometimes make silent judgments to ourselves or prepare rebuttals while supposedly listening: ("She's changed her story around today . . . if I could only remember what she said yesterday, I could point out the contradiction . . . Hmmm . . . Now what was it??"). As the listener becomes aware of your tendency to drift back to your own thoughts, it will become easier to stay focused on the person speaking. Listening is a skill that can be improved with practice.

A useful technique for ensuring effective listening is to share your understandings of the meanings of the communication with the speaker. Occasional observations, such as "it sounds like you were furious" or "you seem to care a great deal about this person," enable the listener to verify his or her understanding of the communication and let the speaker know that real listening is taking place.

Understanding

Always double check with the guest when unsure of the information being given: "I may not have understood that. Are you saying . . .?" When unclear or ambiguous communications are not checked, they could lead to misunderstanding and may contribute to the development of a relationship on false premises.

Showing Empathy

When you are able to experience the emotion a guest is describing and to convey this understanding, you are showing empathy. It is basically non-verbal, even though words may be used. Sympathy is a feeling of sorrow or pity for someone else. Empathy goes one step beyond, by sharing in what the other person feels. It is important for building relationships, for it gives us the feeling that we are not alone—that the other is in the situation with us.

Interpreting Body Language

Facial expressions, physical movements, and the space a guest maintains around him or herself are all methods of communication that you will want to notice. Some refer to this process of observing body language as "picking

up cues." Perhaps a guest who is usually open and talkative is seated alone in the shelter and not looking at anyone who comes nearby. The person is definitely communicating a message, even if you don't know why.

Providing Support

Often the difficulties, uncertainties, and defeats of homelessness lead a guest to feel hopeless and lost. At such times your ability to provide some realistic reassurance, hope, and care can constitute very meaningful assistance to a homeless guest. This doesn't mean helping the guest to pretend that there aren't many obstacles and problems to face. But offering concern and support often assists the homeless person to cope better with the larger problems of his or her life.

GUIDING THE HELPING RELATIONSHIP

As you begin to sense that a degree of rapport has been developed with a particular guest, you can assume that the initial foundations of the helping relationship have been established. As this occurs, you must decide upon your level of willingness and ability to assist the guest. Ideally, you should discuss your intent with the coordinator first. Next, you should make your interest in being of assistance clear to the guest so the guest can understand what is being offered and is able to decide whether and what form of assistance is desired. This typically occurs with the guest identifying a goal or need that he or she wishes to pursue. It can be as concrete as obtaining a shower and clean clothes or as far reaching as permanent housing. When you agree to assist the guest with his or her goal, the helping relationship has begun.

To the extent that the evolving relationship meets some of the guest's needs, it is likely that he or she will continue to participate in it. As this occurs, trust and commitment grow. There are some key tasks that you will need to accomplish in order to make the relationship viable and useful to the guest. These are discussed below.

Goal Setting

Goal setting involves listening and learning from the guest what changes in the present situation are important. Very often a guest will list a multitude of needs, desires, and problems. Sometimes he or she will also express despair or the feeling of being overwhelmed and frustrated about where to begin. Through conversation, you can assist the guest in assigning priorities to the range of goals expressed. "Which are most important?" "What must be accomplished first?" Together, you and the guest begin to organize the problems that have been identified and set a time sequence for their solution. ("This

sounds like the place to begin—those can wait until. . . . ") This process provides a sense of control and direction over what once seemed an overwhelming situation.

Partializing Larger Concerns

Breaking a large goal into smaller and more manageable steps is called "partializing" a goal. While the large goal often feels overwhelming, effective partializing can result in the identification of a series of more readily surmountable steps. These steps ultimately lead to the final goal. If the guest is not

assisted in understanding the relationship between short-term and long-term goals, he or she will be significantly handicapped in the use of the helping relationship. The partializing process, therefore, is a very important one.

Having identified what the person wants in the long run, a job or an apartment, for example, the two of you can figure out what is preventing that goal from being reached. This must be worked out explicitly between you and the guest so that the guest sees the connection between short-term goals not previously considered and long-term goals. For example, if the long-term goals involves the reunification of a guest with her young children, you can assist her in exploring the various steps back toward that goal. These include housing, obtaining public assistance or other entitlements, improved hygiene, and health issues, which are necessary prerequisites for meeting the ultimate goal.

Problem Solving

Once goals have been partialized, you can be of great assistance to the guest in trying to remove barriers to accomplishing the various goals. The problem-solving process has essentially three steps:

1. Analyzing what barriers stand in the way of reaching any given goal. Barriers might be associated with internal issues, such as guest apprehension or anxiety. They may be external, such as a lack of cooperation from others, or the inavailability of social services.
2. Identifying the needed resources for removing the barriers. This could be emotional support or perhaps medication to address internal issues such as anxiety. External barriers may include the absence of transportation or information about public assistance or other social services.
3. Developing an action plan that obtains the resources necessary to surmount the barrier(s) in question.

You can see from this list that a commitment of time and energy above and beyond the role of most shelter volunteers is required to accomplish some of the tasks described. For overnight shelter volunteers, the time required to focus on one guest may not be available, and at times, not appropriate if other guests need attention, too. A helping relationship as described is naturally needed and beneficial for many shelter guests. However, we caution you to assess realistically your ability to complete these tasks once initiated.

Limit Setting

In order to give guests a secure understanding of the shelter and your role as a volunteer, you will want to communicate limits within the shelter. For instance, you can have guests stay overnight but you cannot let them stay during the day—if these are the rules of your program. This is setting limits. Guests can come in until 10 P.M., but cannot come in after 10 P.M. Rules often sound negative, as if you are saying "no" or refusing to provide something, but you are also giving the guests positive knowledge of what to expect. When setting limits, it is important that: (1) everyone knows the rules; (2) they are used consistently; and (3) if an exception is made, everyone is given an explanation and is told that the rule still applies.

Particularly demanding guests may not be so troublesome that you need to ask them to leave, but they can be so annoying that your work may seem nearly impossible. The best policy for this situation is to *set very firm limits.* For example, if a guest has a habit of monopolizing your time to the detriment of

others, an effective strategy could be to say: "I don't have time right now but we can sit down later (give a time) and talk for ten minutes."

Stick to the limits you have set and be consistent; this will establish a pattern to which the guest will hopefully conform. It is best if the whole team of staff and volunteers are consistent, because this type of guest often has the knack of playing off other staff members. For example, "The coordinator [who is not present] always lets me come in after the door is locked. I just need to go out for a minute."

If you are unsure about the rules, make a point of finding them out for the next time. Relationships have boundaries, and you should set them clearly and explicitly for the guests. There will be limits to the time you have to invest, your access outside the shelter, and so on. If you sense that a guest has expectations that are inconsistent with what is appropriate or possible, those limits should be made more clear.

PITFALLS IN THE HELPING RELATIONSHIP

Searching for a Cure or Quick Fix. Meaningful assistance usually entails going through the process of finding a plan of action, then carrying it out in stages toward obtainable goals.

Asking Probing Questions. Homeless people are understandably offended when volunteers are overly intrusive. Stay with ordinary, comfortable conversation.

Having a Savior Complex. In their desire to help, sometimes volunteers assume the role of being the only one to whom a guest can turn to pull him or her through the crisis. This is seldom really the case. Examine your own feelings when you sense you are needed more than anyone else by a particular guest. The problem can be that you are putting your own need (to feel special, for instance) above the guest's need. You may not realize that you are encouraging dependency.

Giving Prescriptions Rather than Assistance. This means the volunteer assumes that he or she is helping the guest by simply pointing out the need ("You should have that ankle checked by a doctor."), rather than offering concrete assistance ("You must be having trouble getting around on that ankle—I'll walk with you to the clinic your caseworker recommended; tomorrow if you like.").

Taking Independent Action. Sometimes volunteers, in their sincere desire to help a guest, will overlook or resist the advice of the coordinator or other staff. While differences in opinions about a guest's needs occur, it is not wise to take action on behalf of a guest without notifying other people in his or her support network.

Overinvolving the Guest in One's Personal Life. Gestures such as making personal loans or giving out home telephone numbers are usually unwise. Sometimes a volunteer acts out of guilt and makes an offer that he or she does not really want to fulfill. Being aware of your personal feelings influencing a decision may help you avoid mistakes which may result in confusion and disappointment.

Know Your Limits

In all helper relationships it is necessary to assess the degree of knowledge and skill needed to assist a guest with a particular problem. Volunteers and workers should especially pay attention to their own abilities and limitations. In reality, many of the problems guests present will require the combined and coordinated effort of staff and volunteers from various organizations. Volunteers are not expected to be the sole source of assistance.

Check with your coordinator and your shelter's screening site. Find out how the guest's problem is perceived and what has already been done, or is being done, on his or her behalf.

Many screening sites are staffed with caseworkers familiar with available resources, and some sites have visiting medical and psychiatric services on the premises. It will be helpful to know who you can contact for a particular problem.

Work with your shelter coordinator to develop a list of community resources available to guests in fields such as medicine, mental health, alcoholism, and so forth, especially for shelters without a screening site. This is referred to as "creating linkages," and it is the best preparation for handling problems that are beyond the capabilities of volunteers or the immediate shelter team.

If you feel you are in over your head with a particular guest, you probably are. Seek advice and assistance when you feel unsure. Of course, referring a guest to someone else doesn't mean that the guest will not need any more assistance. Are you prepared to follow through? Occasionally, it is necessary to accompany the guest to an appointment, or to spend time preparing him or her for what to expect during an office or clinic visit.

When a Helping Relationship Is Not Possible

There are, unfortunately, some people with whom a beneficial relationship is almost impossible to establish. They are:

- Seriously mentally ill people refusing prescribed medication and acting in such a way as to make themselves inaccessible to any other person.
- The intoxicated, chronic alcohol or drug abuser refusing to admit to his or her problem who manipulates the worker/guest relationship so that it remains unproductive.
- Recalcitrant or withdrawn people who consistently shun aid.

In these cases, progress should be measured by small achievements. The most difficult realization for a volunteer—as well as a seasoned professional—is that given the setting and circumstances, not all guests can be helped beyond a certain point. And the guest, after all, has the right to make these choices as long as she or he is not acting in a seriously harmful way. You will do best by rearranging *your* expectations in these cases, rather than making value judgments about the guest.

Some guests will simply not want your help. Just because you are a shelter worker or volunteer and they are guests does not necessarily mean you have better insights or information. There are also guests who do not see themselves as having a problem because, as is the case with some mental illness, their very illness interferes with their insight and judgment. Others, out of a sense of pride and independence, may want to try to solve things on their own. Still others may be satisfied with their current situation, given the limited options available to them, and are not interested in changing their situation right now.

Remember, even if a guest is not currently interested in assistance, this does not mean he or she will never seek it. If the guest is not actively responding, don't think that you aren't helping in any way. Sometimes food, a cup of coffee, and just being there to provide some human contact and concern are more important than you may realize.

SOME FINAL THOUGHTS

One misunderstanding that has caused some disastrous shelter policies is that homeless people do not form relationships or attachments. People have been moved from shelter to shelter and from caseworker to caseworker in seem-

ingly random patterns, often when their need for stability is most critical. While you cannot change much of this, you should become aware of the attachments being built in the shelter. Regardless of whether it's a helping relationship or a much more casual one, care should always be taken where feelings are concerned.

When getting to know a shelter guest, it is helpful to assume from the start that a relationship will build up over time, and that this period will have a beginning, middle, and an end. You will want to let the guest know when you will be available, in what capacity, and for how long, if known. By being realistic and giving careful thought to this beforehand, you will help clarify expectations and avoid such mistakes as making false promises or taking on more than you can handle.

When you and a guest are ending a relationship for some reason (the guest has secured an apartment, for instance), it is important to give attention to this transition. Ironically, attention to ending a helping relationship may begin as it starts, especially in cases where a guest and volunteer will be together only a limited time. Perhaps the shelter has a time limit for guests. Maybe the volunteer is only in the city for one school semester. This must be spelled out in the beginning to prevent unnecessary misunderstandings or disappointments.

You could ideally plan the end of a relationship by sitting down with the guest to review what the relationship has meant and what has been accomplished. This should be done in a way that points out the guest's strengths that contributed to a productive relationship: a likable personality, sense of humor, a knowledge of the bureaucracy, determination, and so on. You could also suggest how these strengths might be transferred into the next situation.

Even when a guest's relationship with the staff or volunteer has not seemed particularly friendly or deep, someone should offer information about any staff or volunteer changes that might affect the guest.

The following chapter discusses homeless families in city-run hotels and in shelters. It provides a brief overview of the special problems of homeless families and offers some guidelines for working with them.

Chapter 2
Homeless Families

You remember the sound of the school playground at recess?
Well it seems like that 24 hours a day around here.
—shelter mother

When homelessness first began attracting public and media attention the issue was defined primarily in terms of single adult men, usually portrayed as elderly, white, and alcoholic. Later, the "bag-lady" stereotype emerged: an elderly, eccentric loner who carried all her possessions with her and who was thought to be mentally ill. This type of homelessness was seen as a big-city problem.

In recent years, much more has been learned about who homeless people are and the circumstances leading to their situation. While some homeless people fit the above descriptions, most do not. Homeless people today tend to be younger, and a growing percentage are members of minority groups. Many are young mothers with small children. Traditional shelters and programs throughout New York City and New York State have found themselves ill-equipped to handle not only increases in numbers of people, but also new problems and needs like job training and child care. Responsibility for meeting these needs has often been spread among a patchwork of agencies.

HOW IS A FAMILY DEFINED?

In New York City shelters, people are classified as a family if at least one parent is accompanied by at least one dependent child under the age of 18 at the time they seek shelter. This classification has been created for the purpose of making shelter assignments and does not conform to the meaning most of us ascribe to the term "family." For example, a teenager who is working and is able to support him or herself would not necessarily be assigned to a family shelter with parents. An elderly mother and daughter would be assigned to a shelter for single women. In reality, most homeless families consist of a single woman with small children.

Many residents of city-run shelters for single men and women have children with whom they are not living. A 1984 New York City HRA study of single residents of city shelters found that 53 percent of the women acknowledged having children. Of those, 26 percent reported at least one child in placement such as foster care. The remainder of the children were residing with relatives or other caretakers, or were on their own. Little is known about the number of single men in shelters who have children and about their role in the care of these children. Often a single person in a shelter represents just one member of a family that has been separated and is in difficulty.

New York City's HRA projects that in 1988 it will shelter approximately 5,200 families on an average night. This figure represents about 17,000 men, women, and children in family groupings. At the same time approximately 11,000 individuals are expected to be sheltered on an average night. It is clear that the number of individuals in family units seeking shelter has now surpassed the number of single individuals.

WHAT CAUSES HOMELESS FAMILIES?

Until recently, the most frequent reason for families losing a residence was eviction for falling behind in rent or a disaster, such as a collapsed building or fire. In 1988, though, the majority of new families seeking shelter have been evicted by the main tenant in a shared household. This change reflects a result of the increased scarcity of affordable housing—families doubled-up in apartments designed for fewer people. It has been estimated that some 50,000 families are illegally doubled-up in New York City Housing Authority apartments, and advocates estimate at least another 50,000 are doubled-up in privately-owned apartments. The problems and tensions inherent in such overcrowded living arrangements are usually unworkable for any length of time.

Families often move from one temporary situation to another before ever having to seek shelter, always hoping to be able to get a place of their own. Although individual circumstances will differ, the overall problem, as with single adults,

is a lack of decent, affordable housing. The vacancy rate in 1988 for all New York City apartments is only two percent, and few are affordable for low income people. For a family of three, the 1988 Public Assistance shelter allowance is $286 a month.

Fifty-five percent of all persons receiving Public Assistance in New York City pay rent higher than their shelter allowance. Recipients sometimes need to cover the cost of housing by using funds designated for other purposes. Presently, there are over 200,000 families on a 10–15 year waiting list for New York City public housing.

The search for housing is a grim and competitive task for all New Yorkers. It is especially difficult for a single woman with small children and severely limited funds; without resources for child care and other needs, the ongoing housing search becomes an almost impossible endeavor.

RESOURCES FOR HOMELESS FAMILIES

A description of the emergency housing system in New York City for homeless families follows. Issues and solutions are becoming more complicated as the number of homeless families increases.

For families who can establish their eligibility for services, the Red Cross is the first source of assistance for homelessness caused by fire or evictions. They are temporarily housed at one of the designated hotels/motels or at one of the family shelters with private family units. Both of these resources, however, are rapidly diminishing as the homeless family crisis grows and the city has had to set priorities in meeting the needs of homeless families. Women in advanced stages of pregnancy, mothers with newborns, and families with a seriously ill or handicapped member are placed in preferential facilities. Victims of fires or vacate orders (evictions) will be given priority access to the city's newly renovated apartments.

For families made homeless by causes other than fire and vacate orders, the first step is a visit to the local Income Maintenance center if the family is on public assistance or may be eligible for public assistance. If the center is unable to locate a hotel room by 5 P.M., the family is referred to the borough's Emergency Assistance Unit (EAU) where a search for a hotel room continues. If none is found, the family is sent to a congregate or barrack-style shelter where, with certain exceptions, they are not to stay for more than 21 days. (Pregnant women and children less than six months old may not be referred to congregate shelters.) Social services at the shelters as well as at the hotels/motels that house homeless families are provided by the HRA's Crisis Intervention Services.

It is helpful to become familiar with the system of emergency housing for homeless families in order to appreciate some of the difficulties they may be experiencing, and to know the facts when trying to assist a family. Additionally, it is important to understand the adverse effect that temporary environs

might have on family members over time. In 1988, the average length of stay in a welfare hotel is about one year.

Some of the more significant effects of sustained homelessness for families are: the development of feelings of hopelessness and dependency, possibly resulting in low self-esteem; displacement of anger on children and a loss of motivation; the reinforcement of perceptions of a lack of control over their own lives; and an increased sense of vulnerability. By anticipating these possible reactions, you may be able to plan ways to reduce their intensity.

The very circumstance of homelessness makes it impossible to assess the parenting skills of a homeless mother.

—case manager

THE HOMELESS PARENT

The ordinary difficulties of childcare—children waking at all hours, feeding, and diapering, etc.—are all multiplied many times over by the conditions of homelessness. The stresses and demands are enormous on the homeless parent, who is usually a young single mother. The uncertainty of living in a temporary situation undermines long-term planning. The parent's main concern is minute-to-minute survival. Other conditions of homelessness contributing to stress and uncertainty are:

- chronic lack of sleep
- the need for constant vigilance

- an overwhelming sense of too many problems
- noisy surroundings
- the threat of having to move at any time
- living in inadequate, cramped quarters
- having no control over many circumstances
- lack of quality time with the children.

Despite these negative conditions, volunteers are often amazed at the strength, perseverance, and even humor that homeless mothers are able to maintain. "I just don't think I could do it if I were in their shoes" is a typical reaction.

Here are suggestions for helping homeless mothers that utilize some of the same principles developed in Chapter 1:

- Help the mother partialize the problems: break them down into manageable parts.
- Identify and try to build on the family's strengths (perseverance, unity, past accomplishments, etc.).
- "Validate" the mother's feelings; let her know that anger, hopelessness, frustration, and other feelings are all understandable, given the circumstances.
- Provide whatever information can be used by the mother on her own, such as housing resources. This will bolster her sense of power and ability to change her situation.
- Let the mother know what her rights are.
- Show her a direction, but allow her to make the decisions for herself and her children.
- Bring in resources: parenting groups, AA, or health services.

HOMELESS CHILDREN

There are many negative conditions seriously affecting the lives of homeless children. Poor nutrition and lack of health care are widespread. Noise, overcrowding, dirt, and a generally irregular lifestyle increase a child's chances of becoming ill.

Studies of children living in these circumstances over time have only begun. In a recent survey, 44 percent of the welfare hotel children seen in a New York City hospital clinic exhibited aggressive behavior, hyperactivity, and signs of depression, compared to 9 percent of the low-income population at large.

Stability is an important element in the social and emotional development of school-age children and adolescents. Maintaining continuity in school presents another problem for a homeless family being moved from place to place; it is one of the biggest issues for the children. Sometimes the solution is for the parent to travel extra distances to a former school with the child;

sometimes the child simply does not attend school for a length of time. Providing stability and consistency is an important goal when working with homeless families.

Protecting Children

Stressful and burdensome living conditions, where a parent lacks support and assistance, can contribute to child neglect and abuse. The homeless parent must contend with numerous survival obstacles, and often has considerable difficulty coping with the needs and demands of children, who are under great stress themselves. In one study of homeless families in New York City, instances of child abuse and neglect were found to be four times more frequent than in other low-income families. Because these families live in institutional settings, bear in mind that they live on display. They conduct their lives in front of case

workers and public officials and, perhaps, have a greater chance of being deemed unfit in some way by outsiders. This perceived threat or risk is often a cause of fear, distrust, or anxiety among homeless parents.

By taking a minute to think of our own families, most of us can recognize how easy it is to find fault with some facet of another person's parenting. When working with people outside one's own cultural and religious background, you may discover vast differences in beliefs, especially in areas like discipline.

Determining if child abuse has occurred is a complex and very serious matter. There are controversies over how to determine when a parent's form of punishment is acceptable and when it crosses the line into abuse.

Abuse is defined as ". . . serious physical injury or sexual abuse" and neglect as ". . . inadequate supply of food, clothing, shelter, and medical care although the parent is financially able to provide for them. Lack of supervision or emotional care, excessive corporal punishment and abandonment."

The critical first step for a volunteer who suspects that a child is being abused or neglected at the shelter is to discuss his or her concerns with the shelter coordinator or director. Together you can work out a plan to address the situation. Further plans should involve consultation with a social worker affiliated with or available to the shelter to assist you with your concerns. The decision *not* to report a situation is best made by a social worker trained to evaluate what might be an unclear or complicated set of circumstances that is difficult for you to assess fully.

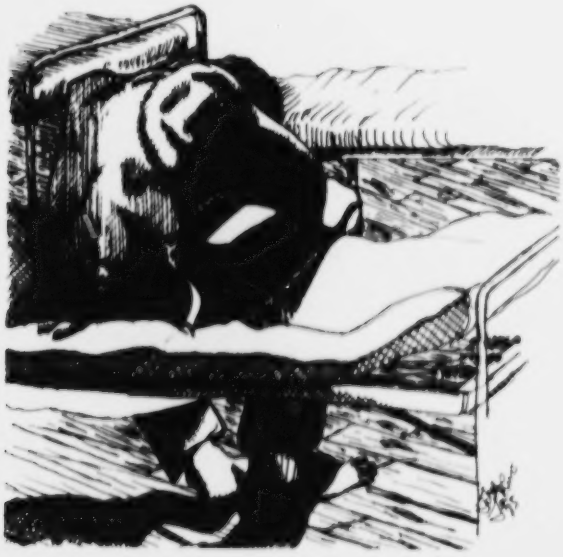
In instances where abuse or neglect is obvious, your shelter coordinator should call the New York State Child Abuse and Maltreatment Reporting Hotline (800-342-3720). Reporting a family is certainly difficult and painful for everyone involved. But it may also be viewed as a way to enlist the aid of professional staff in providing desperately needed services.

SUMMARY

The problems of families living in shelters and temporary hotels can seem to be overwhelming at times, especially when the prospects of obtaining decent affordable permanent housing remain very limited for many families. Certainly temporary shelters cannot meet all of the guests' needs, but remember: emotional support, consistency and usable information can be very valuable in these circumstances. The following chapters on mental illness, alcoholism and substance abuse, and health care will provide a background for some situations you may face. Chapter 7, Advocacy and Chapter 8, Entitlements, will guide you through the maze of social service agencies confronting guests. Refer to these chapters when offering to help guests establish short-term or long-term plans. Any plans that you and a guest devise should be discussed with your shelter coordinator before they are begun.

Chapter 3

Mental Illness Among Homeless People



It's crazy alright, living on the streets—
it can drive you crazy, too.
—shelter resident

Mental health professionals do not necessarily disagree with this statement. There are no firm answers about the origins of mental illness, or about the effects of such conditions as homelessness upon a person's mental health.

Studies of homeless people offer only estimates of the number of mentally ill. These may vary considerably, depending upon the location of the study, the methods used to measure mental illness, and many other factors. A recent survey among single New York City shelter residents found that approximately 25 percent of the residents had either a history of psychiatric hospitalization or current symptoms of a serious mental disorder. Not as much is known in this area about homeless families, but in general, mental illness seems to be less common among homeless families than single individuals.

Before examining the nature of specific mental illnesses, let's consider some of the stresses and conditions that may influence a homeless person's mental health:

- The effect of constant vigilance for safety—lack of sound sleep, fearfulness, suspicion, and insecurity.
- Social isolation—being shunned by others or being treated as invisible. Missing out on ordinary conversation or companionship. Despite the lack of privacy in shelters and public places, huge walls of isolation surround homeless people.
- Use of drugs or alcohol—sometimes loneliness or frustration is relieved by drugs and alcohol. For some people, this is their basic means of creating a sense of community and kinship. Use of these substances can also exacerbate symptoms of mental illness.
- Poor diet—Inadequate nutrition contributes to biochemical imbalances and may cause mood changes. Irregular and improper diet is usually high in carbohydrates, sugar, and caffeine.
- Physical illness—common illnesses among homeless people can cause signs and symptoms of mental illness.
- Being moved from shelter to shelter, or location to location—Uncertainty, disruption, and the inability to build familiarity and routines are extremely wearing, especially if a person has little control over these decisions.
- Lack of medical, psychiatric, or other needed help—obtaining benefits and care is much more difficult for people without a permanent address.
- A pervasive sense of hopelessness and uncertainty brought on by very discouraging circumstances.

CHARACTERISTICS OF MENTAL ILLNESS

For most people, the images of mental illness that first come to mind are the stereotypes found in literature, the media, and films. Sensationalized stories frequently only show the most dramatic effects of an illness. They can also cause fear and stigmatization of all mentally ill people.

In contrast to this, volunteers are often surprised to find that mentally ill guests can be helpful, caring, intelligent, charming, and witty. On the other hand, they also observe people who sometimes struggle with emotions such as fear, anger, or sadness. Some guests have difficulty expressing their feelings and

seem unwilling to communicate at all. Others have trouble putting their thoughts together in such a way that makes sense to other people. This nonconformity can also lead a guest to dress strangely or to do unexpected things.

The most disturbing aspect of mental illness for almost everyone is the inability to predict responses or rapid mood changes. Such unpredictability frequently complicates your task of maintaining a sense of order and safety for staff and guests, and is naturally a prime concern.

Dealing with potentially dangerous behavior is described in detail in Chapter 6, but please remember:

> *The likelihood of physical assault by mentally ill people is very low. Of course it occasionally occurs, but the mentally ill person is much more likely to be self-destructive than aggressive.*

COMMON ADULT MENTAL DISORDERS

Useful Psychiatric Terms For Describing Mental Illness

Psychosis. This is a general term, meaning a severe break with reality has occurred that affects a person's entire personality and ability to function. The term "psychotic" does not mean dangerous; this is a common misperception. The vast majority of psychotic people are not at all dangerous to others.

Delusions. When a person has a belief system based on a distorted view of reality, this person can be described as being delusional. Examples of delusions include false fixed beliefs of persecution ("The CIA is after me"), grandeur ("I am the Queen of England"), and external influences ("Voices told me to do this").

Hallucinations. These are sensory experiences that have no basis in reality. An auditory hallucination is a sound, such as a voice, which no one else can hear. Visual hallucinations can occur, but are less common.

Following are brief descriptions of mental illnesses you may encounter. Please remember that these are very sketchy definitions presented only for the purpose of introducing varieties of mental illnesses.

Schizophrenic Disorders

Features of these illnesses are psychosis and a deterioration from a previous level of functioning in areas like work, social relationships, and care of oneself.

At some time during the illness, hallucinations, delusions, or difficulty forming thoughts occur, but there are many variations and combinations of symptoms. Schizophrenia does not mean split personality or having multiple personalities as is commonly believed. More accurately, it refers to a split from reality.

Schizophrenics have difficulty forming relationships and are often estranged from family and friends, symptoms that can contribute to homelessness and isolation. The schizophrenic may avoid other people, expressing little in the way of emotions. One feature that can occur in schizophrenia is the *inability to organize* thoughts or actions. A schizophrenic may be literally unable to get it together to do an ordinary activity like washing clothes or sending a letter. An individual with this illness may understandably have trouble with punctuality or routine in the shelter.

Some schizophrenics may not have the ability to organize their thoughts into logical, understandable patterns. This is called a thought disorder. Speech may be so totally disorganized that it resembles what has been called word salad. Sometimes the person is so overwhelmed by internal chaos, he or she becomes unable to do anything at all. A term describing extreme cases of this type of immobilization is "catatonic."

Another version of schizophrenia is characterized by fear brought on by a false, but terrifying, belief that someone or something is out to harm the person. "Paranoia" is the term usually used for this type of fear. Among homeless people, of course, fear and suspicion are a part of daily life. However, the beliefs that frighten paranoid schizophrenics are delusions. Because this illness can be characterized by distrust and very real terror, it is extremely difficult to reach and work with most homeless paranoid schizophrenics. They tend to avoid shelters or to be accusing and suspicious of the staff. For example, such a person might wander the streets for fear that the FBI would "get" him if he were to stay in one place for too long.

The onset of schizophrenia usually occurs in early adulthood. There is increasing evidence that it is biochemically caused. The theory that family environment is the primary cause of the disease is no longer as widely accepted. Schizophrenia is a chronic condition that is rarely fully cured. However, medication can greatly improve some schizophrenic patients' ability to function and lead a more normal life.

Affective Disorders

These are disturbances or extremes of a person's mood not due to physical illness, drugs or alcohol, or other types of mental illness. "Affect" means mood or emotional state. Like schizophrenia, affective disorders seem in large measure to be biochemically caused, even though one might think emotional disorders

logically stem from psychological and environmental conditions in the person's past. Examples of affective disorders are discussed below.

Major Depression: This condition is characterized by extreme sadness, loss of interest, loss of pleasure in one's usual activities, severe weight change, oversleeping or insomnia, difficulty concentrating, and anxiety. The feelings last for weeks at a time. Very depressed individuals are almost immobilized

with extreme hopelessness, anxiety, or lethargy. Sometimes they are preoccupied with guilt and have suicidal thoughts. It is to be expected that people in the shelter will be unhappy about their situation, which is a logical reaction. Major depression, however, is a devastating illness compared to that time-limited down-in-the-dumps feeling we all occasionally experience and refer to as depression.

Manic Episodes or Mania: There are many symptoms of mania, but in general, it can be described as being so unnaturally energetic or active that harmful consequences seem inevitable. For instance, if a person is extremely energized for no apparent reason, talking constantly and pacing around so that he or she is unable to sleep for three days, it's reasonable to assume something is wrong. In addition to hyperactivity, other manic behavior might be extreme irritability; an unnaturally euphoric or optimistic mood (this is especially

noticeable when the mood drastically contradicts the reality); inability to sit still; insomnia; inflated self-esteem and grandiosity.

Reckless behavior often accompanies grandiosity. For example, a manic person who claims to control cars with his or her eyes may be found walking in the middle of traffic exercising this presumed power. The person may speak in a loud, repetitive, non-stop manner ("pressured speech") or flamboyantly dress or act in such a way as to call attention to him or herself. A manic episode often looks like a drug "high," and sometimes it's difficult to tell the difference without knowing the person or having experience in substance abuse.

You can see the sort of difficulty this condition might present in a shelter. A manic guest might annoy both staff and other guests by interrupting people, making noise, or wandering around in the middle of the night. He or she may provoke angry reactions, so it's helpful to understand that the guest may be unable to slow down and may need help to manage this behavior.

Personality Disorders

Personality traits are an individual's usual manner of relating to oneself and others. When these traits prevent a person from functioning at work or socially, or if they cause the person distress, then they are considered personality disorders. Unlike previously described disorders, these seem to be psychologically based rather than biochemically caused. The characteristics persist for long, as opposed to short, episodes. Some examples follow.

Borderline Personality Disorder: This disorder is characterized by instability in interpersonal relationships and sudden mood changes. People with this disorder are frequently demanding, manipulative, impulsive, unpredictable, and exasperating for volunteers and staff. One moment they'll be in a normal mood and then switch to intense uncontrollable anger. A guest with this sort of difficulty may show considerable admiration for a volunteer, then turn around unexpectedly and lower that opinion drastically. It's helpful to realize that these opinions aren't to be taken personally.

Anti-social Personality Disorder: The person with this disorder shows behavior characterized by fighting, stealing, and lying, along with the inability to form close relationships with any other people. It usually begins as a pattern before the age of 15.

Dependent Personality Disorder: The features of this disorder are lack of confidence and an inability to function independently, while passively letting others take responsibility for one's own life. Those who experience this condition will often tolerate very poor treatment and harmful circumstances rather than com-

plain and risk losing the person or situation upon whom he or she is dependent.

Narcissistic Personality Disorder: Characteristics include a grandiose sense of self-importance or uniqueness, a need for constant attention, preoccupation with fantasies of success, and inconsiderate manipulation of other people. Reaction to criticism is usually rage, shame, and inferiority due to a fragile self-esteem.

Organic Mental Disorders

Symptoms are loss of memory, slowness, poor concentration, irritation, and uneven levels of alertness. They differ from psychiatric disorders in that they are usually caused by physical damage, physical illness, or deterioration, such as recent trauma to the head, seizures, or drug and alcohol abuse. Organic and psychiatric disorders often look alike. Therefore, if you suspect that a guest is suffering from such a disorder, it is particularly important to seek a comprehensive evaluation by a qualified physician.

Mental Retardation and Developmental Disorders

Physiological in their basis, these conditions first appear at birth or in early childhood, and range from hyperactivity with difficulty concentrating, memory problems, and poor impulse control to problems with reading, mathematics, and language. As with organic mental disorders, mental retardation is sometimes mistaken as a psychiatric disorder due to the similarity of some of the symptoms. One difference is that psychiatric symptoms may flare up and then subside, but mental retardation is an impairment that is even over time.

Dual Diagnosis

Substance abuse is a diagnostic category by itself according to mental health professionals. When a person is diagnosed as having two separate illnesses, the term "dual diagnosis" applies. Recently the term has been used for an increased number of young, poor, homeless people who are both mentally ill and dependent on chemicals such as drugs and alcohol.

Detailed information on these and other conditions may be found in the American Psychiatric Association's publication *Diagnostic and Statistical Manual of Mental Disorders* (DSM III). It is a primary reference book for mental health professionals containing definitions and criteria for all categories of psychiatric illnesses. These definitions represent attempts to classify the various forms mental illness can take. Opinions differ both within and outside of psychiatry on how the labels are used. Such controversy emphasizes the need for increased

sensitivity to how cultural, class, racial, and gender biases influence some perspectives. Volunteers should remember that the mental health field is not an exact science and constantly grows and changes in the search for knowledge.

WORKING WITH MENTALLY ILL GUESTS

One of the signs of mental illness is a break with reality and the development of delusions. Although reality is somewhat subjective, there are some things that just about everyone agrees on. For instance, when we turn on a radio, we hear broadcasts from radio stations. A person who hears his or her own thoughts being broadcast from the speakers is hearing something that the rest of us know is not real.

Disagreeing with what is considered normal is not necessarily a sign of mental illness, but having an inability to perceive generally recognized objects and events, especially when pain and unhappiness result, is an indication of illness. Very often, mistaken beliefs are firmly entrenched in a mentally ill person's

thinking and behavior. When talking with a delusional shelter guest, *trying to challenge or deny these beliefs often leads nowhere as they are indeed reality as the mentally ill person experiences it.* No matter how much logic or reasoning you use to try to convince the guest to see things your way, it will probably not make sense according to his or her sense of logic. In order to help the guest, try instead to focus the conversation on reality as much as possible. For the most part, it's best to avoid pretending agreement with what is not real. Just steer the conversation back to the real parts.

For example, if a guest claims that her deceased husband owns Manhattan, Tiffany's, and the shelter, you might say: "Your husband must have been an important man. Tell me about him. How long were you married? Do you have any children?" This response doesn't challenge what the guest has said about her husband nor does it indicate agreement with the husband's ownership of various properties. Responding to the guest's sense of her husband as important and trying to redirect the conversation toward more routine facts may help the guest express how her husband has *actually* been important to her. If this approach is successful, it begins to lay the foundation for future contact that may assist the guest to deal better with reality.

Keep in mind that other areas of functioning can be perfectly normal or above average even though a delusional person may have several false beliefs. Delusional people are not necessarily more forgetful or less capable than others. Mentally ill guests can be very insightful and sensitive to the staff and other guests, much to the surprise of inexperienced volunteers.

Remember, too, that many mental illnesses do not include delusions or hallucinations. Other characteristics are much more ordinary, and some are, quite frankly, annoying to cope with unless you understand that they are symptoms of an illness. These include aggressiveness, clinging, chronic complaints about health problems, oversensitivity, insensitivity, self-proclaimed superiority, and argumentativeness. Because these characteristics are more familiar among the general population, you may miss important clues to the nature and extent of the guest's problem. Instead, try to understand and empathize with what the person feels and needs. You may at times feel anger, frustration, hurt feelings, etc., and this is to be expected. Try to handle these feelings in a manner that best enables you to support all of the guests in meeting their immediate needs. This is, of course, your main objective.

How to Begin

As with any helping relationship, it is important to begin with interactions that engender trust and respect. This is the basis for any productive work. The guest needs to feel comfortable with you and vice versa. Being consistent and

trustworthy in words and action helps create some stability for a mentally ill person.

When trying to help a mentally ill guest, your goal should not be to change or eliminate mental illness, but to work with the guest to manage his or her illness in a way that protects the person and promotes healthier functioning. Mental illness is a chronic condition, just like diabetes or hypertension. As noted above, it often can be effectively managed, but it is rarely cured.

Realistic counseling objectives, therefore, include:

- Attempting to manage or decrease stresses and sources of stress.
- Trying to manage or decrease behavior that violates the rights of others.
- Avoiding the attempt to cure psychiatric symptoms.

Volunteers need not assume an air of professional detachment when working with a mentally ill guest. Instead, select and relate feelings and thoughts to the troubled guest that you judge will be helpful to him or her. With practice, your skills at picking up cues from a guest will support your judgment. Mistakes are part of the learning process of gaining experience and are valuable when acknowledged.

Remember, your best approach is not to become preoccupied with diagnosing or curing mental illness, but to help the guest cope better with his or her situation. Where possible, encourage the guest to accept help from a mental health clinic or professional and have referral information available.

Setting and Implementing Limits

Each shelter has its own set of expectations defining appropriate behavior for guests, staff, and volunteers. Sometimes in an attempt to be hospitable, rules and regulations are not formalized or are overlooked for favorite or regular guests. Be mindful that this is a risky practice, which can lead to difficult situations for everyone. It is best that the rules governing the shelter be available and understood by everyone. They should be enforced equitably, without special treatment. Rules set the parameters of acceptable behavior.

Despite their illness, most mentally ill people are capable of understanding and complying with rules. If a mentally ill guest is disruptive, the ground rules should be reiterated and enforced. You should try to discover what caused the outburst and attempt to ease the situation. Even mentally ill persons should, however, understand that they are accountable for their disorderly behavior.

This is not to suggest that problematic guests be evicted because of their illness. If a guest is too disruptive, he or she might be asked to leave the area

(and sometimes the shelter) until he or she is calmer and in control again. Find out the exact policy from your shelter coordinator so you will be prepared for this possibility.

Remember: *Address the behavior of the guest and not the illness.*

PSYCHOTROPIC MEDICATION

"Psychotropic medication" is the term used to describe drugs prescribed by doctors to help reduce the symptoms and distress of psychiatrically disturbed people. These drugs act by altering brain chemistry to improve the person's functioning by, for example, reducing anxiety or controlling hallucinations.

These medications require ongoing monitoring by a regular physician. Outpatient clinics, where most homeless, mentally ill people go for treatment sometimes cannot provide adequate supervision, particularly if the homeless person does not attend regularly. It is important, therefore, to pay attention to changes in guests that may be caused by medication problems.

Psychotropic drugs can be of great help to some individuals. For example, people have reported that medication allowed them to sleep restfully again as a result of decreasing unwanted frightening thoughts and anxiety at night. Some very withdrawn and disorganized people have been able once again to put

sentences together and to begin relating to others after treatment with medication. Allowing a person to reclaim previously hidden parts of his or her personality can be a very rewarding result in psychotropic drugs and comprehensive care.

Along with these possible benefits, however, are possible negative side effects, or in some cases, no effect at all. This may influence a mentally ill person's choice not to take medication. A guest may discontinue medication for the very rational reason that it makes him or her too drowsy to be safely alert on the streets. Others may have had unpleasant physical side effects and might not know that with proper monitoring, medication can often be modified in type and dosage to reduce the undesirable side effects.

In general, guests on psychotropic medications decide to stop taking a drug and/or to break the prescribed treatment agreement for one or more of the following reasons:

- Inability to understand or to recall the doctor's instructions.
- Lack of motivation to carry out the treatment plan (of which medication is one part).
- Negative side effects beyond the individual's level of tolerance.
- Lack of trust in the physician.
- The belief that the medication will not help and might even cause harm.
- An individual believing he or she is not ill and does not need medication.
- Medication vacation or discontinuing medication in the hope that the condition has changed.
- Inconvenience of clinic visits and medication regimes.

When discussing medication with a guest, it is best not to suggest automatically taking pills and keeping to a medication plan. Conversely, avoid automatically agreeing with a guest's wish to stop medication due to the development of serious side effects. Such perfunctory responses are discouraged because they may prevent you and the guest from exploring different sides of the issue for that unique individual. You may, however, be able to help the person think about and talk about these issues and to bring them to the attention of the coordinator.

Psychotropic Medication Guide

The accompanying table of psychotropic medication provides a listing of the most commonly prescribed medications used in the treatment of mental disorders. Each medication is listed by its generic name followed by the brand

or trade name in parentheses, which is more commonly used. The usual dosage is listed along with possible side effects.

Because many mentally ill guests do take psychotropic medication and talk openly about it, you may find it useful to become familiar with the more common preparations and their possible side effects. We provide this information not to encourage you to take on a prescribing physician's role, but as a reference that may be of use in discussing medication issues with clinic staff or guests.

*A GUIDE TO PSYCHOTROPIC MEDICATIONS**

Antipsychotics (major tranquilizers)

Since antipsychotics may impair mental and/or physical abilities, performance of potentially hazardous tasks should be cautioned and the use of alcohol should be avoided.

Drug Name (TRADE NAME)	Usual Daily Dosage Range	Use	Possible Side Effects
Chlorpromazine (THORAZINE)	150–1500 mg.	To reduce overt disturbed behavior and effect delusional beliefs and hallucinations. Used to reduce severe agitation, aggressiveness, and tension, nausea and vomiting; control of hyperactivity in mania.	Antipsychotic medications may cause a Parkinsonian-like reaction, characterized by tremors, stiffness, or shuffling gait. May also cause drowsiness, jaundice, fainting, restlessness, muscle spasms, dry mouth, blurred vision, nasal congestion, constipation, increases in appetite and weight. Note that although the side effects of the antipsychotic medications are similar, each has a somewhat different effect, i.e., one may be more likely to cause fainting and another excessive stiffness.
Thioridazine (MELLARIL)	150–800 mg.		
Trifluoperazine (STELAZINE)	10–60 mg.		
Perphenazine (TRILAFON)	12–60 mg.		
Haloperidol (HALDOL)	2–40 mg.		
Thiothizene (NAVANE)	10–60 mg.		
Molindone (MOBAN)	15–225 mg.		
Loxapine (LOXITANE)	10–100 mg.		
Fluphenazine (PROLIXIN PERMITIL)	Patient can be given an injection once or twice a week on a regular schedule.		

Antidepressants

These medications may require one to three weeks of administrations before the therapeutic effect is obvious.

Drug Name (TRADE NAME)	Usual Daily Dosage Range	Use	Possible Side Effects
Imipramine (TOFRANIL; SK-PRAMINE; JANIMINE)	100–300 mg. in divided doses	Relief of major depression symptoms and some manic disorders. Helpful for depressed mood, abnormal sleep patterns, abnormal concentration.	Dry mouth; anxiety; insomnia; nightmares; sexual dysfunction; tingling; incoordination; tremors; blurred vision; constipation; skin rash; photosensitivity; nausea, vomiting & diarrhea; jaundice; abdominal cramps; sweating; dizziness; weakness; headaches.
Amitriptyline (ELAVIL; ENDEP; ETRAFON)	50–300 mg.		
Desipramine (NORPRAMINE; PERTOFRANE)	100–250 mg.		
Doxepin (SINEQUAN; ADAPIN)	75–300 mg.		
Other Antidepressants and Adjuncts			
Methylphenidate (RITALIN)	20–30 mg.	Relief of hyperactivity. Sleep disorders. Apathy in elderly patients. Minimal brain damage syndrome in children.	Nervousness; insomnia; skin rash, fever, dizziness; nausea; irregular pulse; abdominal cramps; loss of appetite and weight loss; blurring of vision.

Antianxiety Medications (minor tranquilizers)

Drug Name (TRADE NAME)	Usual Daily Dosage Range	Use	Possible Side Effects
Chlordiazepoxide (LIBRIUM, LIBRITABS)	15–100 mg.	Reduces symptoms of anxiety. Relieves muscle spasms. May help a person to fall asleep. Decreases feelings of apprehension and allows person greater feeling of control.	May cause drowsiness, confusion, skin rash, nausea & constipation, tremors, muscle twitches, slurred speech, sexual dysfunction.
Meprobamate (MILTOWN, (EQUANIL)	800–1600 mg.		
Diazepam (VALIUM, VALRELEASE)	4–40 mg.		

Antiparkinsonian Medications

Drug Name (TRADE NAME)	Usual Daily Dosage Range	Use	Possible Side Effects
Trihexyphenidyl (ARTANE)	6–20 mg.	To treat stiffness and symptoms caused by antipsychotic medication.	Dry mouth, blurred vision, dizziness, mild nausea or nervousness, skin rash, constipation, urinary hesitance or retention.
Benztropine (COGENTIN)	2–6 mg.		

Antimania Medications

Maintaining a regular blood level is very important when undergoing treatment with Lithium. Repeated blood level tests are required with medical supervision, and it is essential to maintain a proper diet, including salt and adequate fluid intake.

Drug Name (TRADE NAME)	Usual Daily Dosage Range	Use	Possible Side Effects
Lithium (LITHANE, ESKALITH)	900–2100 mg.	For symptoms of mania, reducing grandiosity, hyperactivity, over-talkativeness, etc. Sometimes used for major depression.	May cause hand tremors, muscle twitches, blackout spells, urinary frequency, restlessness, confusion, nausea and vomiting, diarrhea, drying and thinning of hair; blurred vision, dry mouth, fatigue, lethargy, weight loss, increased thirst, acne, itching.

Antiseizure Medication

Drug Name (TRADE NAME)	Usual Daily Dosage Range	Use	Possible Side Effects
Carbamezepine (TEGRETOL)	800–1200 mg.	For seizure disorders. Has been used to treat mania and depression in some patients.	Dizziness, drowsiness, unsteadiness, nausea; skin rash, headache, fatigue, blurred vision; fever and chills, joint and muscle aches.

Medications Used for Alcoholism

Drinking alcohol when taking ANTABUSE causes the following symptoms: flushing; throbbing in the head and neck; nausea; respiratory difficulties; vomiting; sweating; tachycardia; fall in blood pressure; weakness; vertigo; blurred vision and confusion.

Drug Name (TRADE NAME)	Usual Daily Dosage Range	Use	Possible Side Effects
Disulfiram (ANTABUSE, ALCOPHOBIN)	125–500 mg.	To discourage the intake of alcohol for some chronic alcoholic people who want to remain sober.	Mild drowsiness, fatigue, headaches; acne, unpleasant aftertaste.

*Adapted from "A Guide to Psychotropic Medications," A. Skodol, M.D. and L. Sharpe, M.D., consultants to Columbia University Community Services.

WHEN A GUEST IS THOUGHT TO BE SUICIDAL

Early Signs: There are no fail-safe methods to determine whether a person will or will not take action. Often the guest will show signs of hopelessness and despair enough in advance that you can get help for him or her. Look for signs of: withdrawal; increased alienation or isolation; manic (hyperactive) behavior; extreme hopelessness; talk about dying; feelings of guilt or worthlessness; constant fatigue; anger or sense of loss; and inability to imagine any change for the better.

Listen to what the guest is saying. If he or she talks frequently about death, even jokingly, it should be taken seriously and be brought to the attention of the supervisor.

Who Attempts Suicide?

- People who can no longer cope with the problems in their lives. They are often undecided, not really wanting to die, but not wanting things the way they are.
- People who use the threat of suicide to control or hurt others. Often they seem to be directing their action to a particular person close to them.
- People experiencing severe depression. This can often occur at the point when he or she is actually beginning to improve. The cause of the depression may be biochemical or related to external conditions.
- Actively psychotic and unpredictable people. Though only a small percentage of homeless, mentally ill people could be included in this group,

guests who experience command hallucinations, with voices telling them to hurt themselves, are at serious risk.

What to Do for a Potentially Suicidal Person

The best way to verify suspicions is by asking the person a direct question. For example, if the person says, "The world would be better off without me," an appropriate response would be: "Do you think about hurting yourself?" Finding out if the person has made specific plans is one way to determine how serious the situation is. If the person is thinking about suicide, discuss the possibility of going to the hospital.

If he or she agrees, go along to the hospital and *don't* leave until admission is completed if possible.

Keeping the person talking is not enough, however. Try to convey a real concern and understanding of what the person is feeling (empathy). This gives the troubled guest a sense of being connected. You may get someone the guest feels especially close to—another shelter guest or worker—to help with talking to him or her. In a temporary shelter, the coordinator and staff at the screening site should be notified.

If the guest refuses *and* is actively self-destructive, call the police at 911.

Even if the guest is successful in weathering the immediate crisis without hospitalization, thoughts or impulses to commit suicide may return soon after. The guest may back off saying he or she didn't mean it, perhaps out of shame or fear of hospitalization, even though the thoughts persist. For these reasons,

it's important for staff to monitor the person closely until a psychiatrist can more fully determine whether the guest remains at risk. In any case, try to ensure follow-up counseling for the guest.

INVOLUNTARY COMMITMENT

The decision to seek involuntary commitment for a shelter guest to a psychiatric hospital is a difficult one and raises complex questions and concerns. It typically occurs when the police are called for either violent or suicidal behavior. Some people express legitimate doubts about the helpfulness of this solution; yet it may be the only alternative in situations where a guest must be protected from harming him- or herself or others. You should ideally enlist the judgment of the coordinator and other staff if involuntary commitment seems to be necessary.

Dialing 911 to have the police take the guest to a hospital is only the first step. For a person to be admitted involuntarily, two physicians must decide to keep the patient in the hospital. This is called a "2 PC" (Physicians Certificate). It requires that two physicians find the person mentally ill and in dire need of hospitalization. The doctors must ascertain that the person's judgment is so impaired that he or she does not understand the acute need for hospitalization. It further requires that the person be unable to take care of him- or herself, or exhibit behavior that would result in serious physical harm to self or to others.

Although the choice to seek involuntary commitment is extremely rare in overnight voluntary shelters, it is clearly appropriate in some instances. Seek this option if the guest seems capable of "serious physical harm" or demonstrates an absolute and clear inability to take care of him- or herself over time.

SUMMARY

As you can see, working with mentally ill homeless people is not fundamentally different from working with other shelter guests. It is especially important to listen and learn from them about their thoughts and feelings. Do not feel that you are responsible for the cure of your guests, but rather approach the task as one of helping them to manage as best as they can. By being part of a stable environment, you benefit the guest considerably.

The next chapter, which discusses the problem of alcohol and substance abuse, will provide further insight into working with shelter guests.

Chapter 4

Alcoholism and Substance Abuse

Nothing else ever had the same effect for me.
I knew it was 'my' drug the first time I tried it
with a friend in high school. She isn't addicted . . . I am.
Why me? Why not her?
—women's shelter resident

Alcoholism and substance abuse are complex topics that take time, study, and experience to begin to understand. Even among experts in this field, there are differing opinions on some very fundamental questions: Does addiction occur more readily in some people than others? Why does it happen? What is the best method of treatment? Is dependence on drugs or alcohol ever really cured?

You will invariably encounter guests who are struggling with a dependence on drugs or alcohol. This is not a condition unique to shelters, substance abuse exists in every part of society. It is not bound by race, class, sex, or age. Needless to say, the consequences of substance abuse considerably compounds the other conditions of homelessness.

The myth that all homeless people are alcoholics has by and large been dismissed by recent studies showing the vast diversity in homeless people and their problems. In fact, only a minority percentage of homeless people are addicted to alcohol or other chemical substances. This chapter is designed to help you begin to understand addiction and to learn some of the more useful ways to cope with this problem in the shelter setting.

TERMINOLOGY

Some professionals draw a distinction between addiction, dependence, and abuse. For this chapter the terms are used interchangeably. The words "chemical," "drug," and "substance" are all used to describe the following items one ingests orally, by inhaling, or intravenously: alcohol, amphetamines (sometimes called uppers), barbituates (sometimes called downers), heroin, cocaine, and hallucinogens. Life-sustaining drugs, such as penicillin, are not included in this list. They are not mood-altering chemicals and are used for an entirely different purpose.

ADDICTION

All drugs act on the body. Addiction, however, is the habitual and compulsive use of a drug or drugs.

Individuals offer different explanations for their acquisitions of damaging drug or alcohol habits. The process of becoming addicted is a multifaceted phenomenon. Some people begin by self-medicating, i.e., using drugs or alcohol to control emotional pain, depression, or anger. Others become addicted to medication prescribed for chronic physical pain.

These substances are habit forming because they eventually create a biological need for the drug and/or powerfully reinforce the psychological drive to continue in this manner. When people are unable to control their intake of a drug, they probably have crossed the line from occasional use to addiction or dependence. Chemical dependency is the same whether people use legal drugs (alcohol), prescribed drugs (Valium, amphetamines), or illegal drugs (heroin or crack). It is characterized by a compulsive need for drugs.

There are three major components of dependence on chemicals:

Biochemical-Genetic: The body becomes physically dependent on a chemical in order to maintain homeostatis (equilibrium). Tolerance, a physical response, builds up with drug usage, and one needs more of the substance to feel its euphoric effects.

Eventually, one needs more and more to maintain "the high" or even to feel normal. Without the drug the person may show physical signs of withdrawal such as nausea, trembling, or profuse sweating. Individual physical responses to drugs and predisposition to dependence is thought to be a function of heredity and genetic makeup.

Psychological: This aspect is, perhaps, more difficult to overcome than the physical addiction. The person becomes increasingly obsessive about the drug, and these thoughts begin taking the place of all other thoughts. In the absence

of the compulsive activity, the person may become irritable and nervous. Frequently, a recovering alcoholic will attempt to combat psychological associations of drinking, for instance, by carrying around a glass of water or juice long past the physical detoxification.

Sociocultural: Drugs are all around us. They are part of our culture. Our usage is directly influenced by our circle of friends, and by society at large. Saying no to drugs may mean breaking from an ingrained tradition. It may mean alienation from one's group, perhaps even family members and lifelong friends. This pressure, both subtle and obvious, is helpful to understand.

Trying to Understand

Most of us accept that there are very damaging aspects of chemical dependency. It is also important, however, to recognize the attractive aspects that lead a person to maintain his or her habit. Drugs can pick you up or slow you down; you can control mood changes. These substances may alleviate boredom and loneliness for a while. They may make a person temporarily feel good despite unhappy circumstances. For homeless people experiencing discomfort and distress, it is understandable that the "benefits" of drugs may be very appealing, especially if the negative effects are ignored. People who become addicted to chemicals are not necessarily self-destructive individuals. For some, use of these substances is their only known way of trying to cope with pain or disillusionment despite the resulting damage.

Denial

In order to justify and protect the desired effects of substances, the chemically dependent person will often downplay or refuse to see the damage being done. This is often referred to as denial. The person may insist that he or she does not have a problem, or that his or her drinking or drug usage is under control, and may genuinely believe this story. Although on some level the person may feel ashamed and terrible about the harmful effects of his or her addiction, there's an essential unwillingness to part with the "benefits." Thus, he or she unconsciously constructs excuses or develops rationalizations to dismiss obvious truths.

Yeah, I like to get high but I don't cause any trouble. Why should that bother anybody? I'll bet nobody comes in your home and tells you what to do. I may be in this shelter, but I'm not a child . . . I'm grown.

—shelter resident

YOUR ROLE

First, find out the shelter's rules about drinking and drug use. Find out exactly what is expected if a guest's drinking, for instance, is a problem, and be prepared to be consistent with the rules.

Volunteers are not expected to be substance abuse experts; this is a specialized role, requiring extensive training. What you can do for a guest is to offer support and information. The same advice given throughout this booklet applies here, too: a relationship built on trust and respect is the foundation for bringing about positive changes in another person's life.

You should guard against making quick diagnoses of inebriation, alcoholism, or drug addiction on the basis of limited contact with guests. Knowing if a person is high on drugs or alcohol is not always easy. The effects of some medication and some physical illnesses can be mistaken for intoxication. Getting to know the person is the best way to pick up clues about a substance abuse problem. For volunteers who spend limited time with guests, it is important to discuss concerns about a possibly chemically dependent guest with the coordinator. With time and the development of a relationship, some alcoholics or drug abusers will tell you about their usage, but in most cases they will not. You will have only the consequences of possible addiction to work with: loss of income, poor health, limited social acceptance, and limited personal security.

Working with a Substance Abuser

When you feel a guest may be troubled by dependence on drugs or alcohol, and the person's behavior is within the guidelines of the shelter's rules, the best place to begin in building a relationship is to communicate a sense of acceptance. Let the guest know that you see and value the positive aspects of his or her personality. If possible, avoid expressing an attitude of disapproval, which might be interpreted as a lack of acceptance. The goal is not to present the most logical, factual argument to destroy every excuse the person makes about his or her dependency, but rather to strengthen their good and healthy behavior.

You may ask a guest about alcohol or drug usage, but it is best to avoid confrontation or accusations whenever possible. Don't try to break through his or her denial that a problem exists. Provoking anger is counterproductive in most cases. (At times such provocation is used by experienced drug and alcoholism counselors when judged to be potentially useful to a particular client.) People who are dependent on chemicals already are burdened with guilt and low self-esteem. Knocking them down is not the most helpful way to prepare them for the challenge of overcoming an addiction. When working with a substance abuser, your best role is to support and encourage the guest toward making a decision to get help, and be prepared with referral information if needed.

When a Guest is Inebriated or High

First, shelter guests and volunteers need to have a clear knowledge of the rules concerning drugs and alcohol. Be prepared to enforce these rules. If guests show up at the shelter unmistakably under the influence of drugs or alcohol, their behavior may make it necessary to deal with the subject of drinking or drugs at that time. A direct reference to a guest's state may cause an irritated or defensive response. It is recommended that such confrontations take place with another volunteer or staff person nearby as a routine safety precaution, and the coordinator should be notified if possible.

A guest under the influence of drugs may try to draw you into a discussion or argument. Such discussions are seldom productive or helpful to the guest. A few minutes are usually sufficient to communicate whatever needs to be said about rules and behavior. Set firm limits and be consistent.

Enabling the Guest to Continue

Sometimes, because they feel sorry for the substance abuser, people try to help by covering up negative behavior caused by drugs. This is called "enabling" because it allows the person to continue such behavior. An example would be

Any sick person wonders what he or she did to bring on the illness, but the results of alcoholic drinking generate more shame, guilt, depression, and low self-esteem than almost any other illness.

—medical doctor

a wife who apologizes and makes excuses for her husband who consistently misses work because of his drinking. A volunteer who overlooks the rules about drinking in the shelter for a particular guest may be doing more harm than good in the long run.

When Efforts Don't Work

Overcoming chemical dependence takes time and patience, and there are people who will not respond to the help and support you give. Feeling guilt or a sense of failure over another person's actions or inactions can turn into fruitless anger and frustration. There is a difference between helping a guest help him or herself and inappropriately taking on the guest's responsibility for his or her recovery. That responsibility rightfully belongs to that person alone.

If a Guest Acknowledges a Problem with Drugs or Alcohol

- Enlist the support of the coordinator or other involved staff.
- Let him or her know that the problem is treatable. Hope is essential. Affirm that change is possible and achievable. Others have overcome addictions.
- Develop realistic expectations for the immediate future. Remember that alcoholism and drug addiction are chronic conditions and that a repeated cycle of partial recovery, backsliding, and partial recovery may be expected. This is an especially important idea to accept.
- Recommend an Alcoholics Anonymous-type program after determining that the guest may be ready to follow through. Or recommend that the person call the N.Y. State Drug Abuse Information Hotline (listed at the end of this chapter). Make a promise, if you are prepared to do so, to remain in contact during the process.
- Help the guest develop alternative strategies for the management of the daily life experiences that were previously coped with by alcohol or drug use. Remember that an addict will be facing pains and disappointments without a crutch, perhaps for the first time in years. Recovery is a long process that begins when he or she stops using chemicals.

ALCOHOLICS ANONYMOUS AND OTHER RESOURCES

Alcoholics Anonymous (AA) is an informal fellowship of men and women who offer peer support to each other in order to remain sober. It has chapters in cities and towns throughout the world that meet regularly so that alcoholics can share with each other their experiences and methods of coping with this illness.

AA believes alcohol is beyond the control of the alcoholic—that after taking just one drink, he or she cannot stop. Therefore, they feel the alcoholic *must* avoid that first drink.

One method of not drinking commonly used by AA is the 24-hour plan. They concentrate on getting through one day at a time without drinking. If the person has the urge, it is delayed until the next day. Meanwhile, he or she considers the consequences of that first drink and contacts a fellow AA member for help.

AA can and has worked for all types of alcoholics, regardless of social class or degree of addiction. Contact the AA program in your neighborhood for support and information.

The central office telephone number for AA is 212-473-6200. You can get a referral to AA groups in all five boroughs plus Westchester and Nassau County.

Other groups built on the model of AA include:

GA—Gamblers Anonymous

Al-Anon—for relatives and spouses of alcoholics

NA—Narcotics Anonymous

DA—Drugs Anonymous

The telephone numbers for these groups are available from:

The National Self-Help Clearinghouse

718-788-8787 (9:30 A.M. to 5:30 P.M.)

Another useful resource is the N.Y. State Division of Substance Abuse Services:

Drug Abuse Information Hotline

800-522-5353 (24 hours a day)

Other Steps

As a member of the community, a religious club, or civic group, there are many things you can do to deepen your understanding of substance abuse and to promote prevention. Some suggestions are:

- Take an active part by offering your time in support of community drug abuse efforts.
- Learn as much as possible about the nature and symptoms of drug abuse.
- Learn where all sources of assistance are. Develop a resource list for your shelter.
- Arrange for training seminars for your group of volunteers.
- Let the shelter guests know if you are involved with community drug prevention or treatment groups.
- Develop mutually agreed upon guidelines for shelter guests and staff regarding suspected substance abuse, contraband disposal, and other related issues.
- Assist with development of funding resources for community substance abuse programs, facilities, and supplies.

SUMMARY

As you have seen, the effects of substance abuse can be a complex and difficult issue when dealing with chemically dependent guests. Remember that you are not responsible for their behavior, but rather can support and encourage their positive actions and attributes. Certainly you should encourage any guest who seems willing to enter a substance abuse program. Measure whatever gains are made by the guest as steps toward an eventual goal, and avoid blaming yourself for another person's decision when dealing with drugs or alcohol.

The next chapter, Health Care, will provide information to aid you with guests having a variety of physical illnesses that are often aggravated by being homeless.

Chapter 5

Health Care

An old man with no money like me?
They'll leave me for last. I don't think they want to bother with me.
—elderly homeless man in a New York City hospital clinic

Homeless people are subject to a wide variety of physical and mental problems that are further aggravated by life on the streets and in temporary shelters. Many barriers prevent these people from obtaining needed medical care: extensive waits, lack of entitlements, lack of funds, unwillingness or inability to go through with treatment, and distrust of the medical establishment. Patience and perseverance are required to help overcome these barriers for guests.

In addition, homeless people have reported being treated badly by the staff of medical institutions. This may be because some homeless people appear dirty and ragged, and are seen by hospital staff as undeserving of this resource.

A person waiting to be seen for bronchitis may be taken before a homeless person who may have a more serious condition. This is wrong; a volunteer or worker accompanying the homeless person may try to correct this circumstance. On the other hand, victims of a car accident may rightfully be seen before a homeless person with a less immediate health problem.

Hospital and medical professionals, in turn, have needs and priorities that must be taken into consideration. They have been ill-equipped to deal with a sick homeless person whose immediate needs include a bath, clean clothes, new shoes, and a safe place to sleep and recuperate. Doctors and nurses become frustrated with patients who are unable to carry out a medication regime, or whose living situation almost guarantees repeated illnesses.

FINDING MEDICAL ASSISTANCE

You should become familiar with the needs and limitations of your guests and of the hospitals in your area. You may want to find out what medical facilities are nearby and what sort of relationship, if any, has been established between the shelter (or screening site) and the hospital.

It is not uncommon to find that a guest has sought help from a whole array of separate programs and people, a sort of patchwork of agencies that has not been able to coordinate activities in order to solve the guest's problems. This can be very frustrating and tiring for a guest. Check first to find out *who* has already done (or initiated) *what* for the guest, to avoid such duplication as making an appointment with a doctor for a guest when a caseworker has already set up a clinic appointment for the same thing.

You can't really blame the guest for allowing duplications—he or she may have fallen through the cracks enough times to make it seem logical to overbook sometimes. But you do want to work efficiently with other agencies.

Emergency rooms are used for acute and life-threatening conditions. Some ERs have an adjacent area where patients are screened to determine the urgency of the problem. This keeps the ER clear for emergencies like gunshot wounds or heart attacks. Other problems that are serious but not life-threatening—such as an ear infection, a sprained ankle, or leg ulcers—will be cared for in the screening area. Ideally, the care given in a screening area would be provided in a doctor's office or in an outpatient department. All shelters should have arrangements with a hospital outpatient department or clinic in order to avoid inappropriate use of the ER.

In the event of illness, it is far better for a guest, and more cost effective for the hospital, to obtain early medical help in a clinic or doctor's office rather than waiting until a trip to the ER is necessary.

For non-emergency care, it is best to check with the shelter coordinator to

find out the customary routines for providing medical care. These are extremely subjective in New York City where such variables as location, nature of the illness, and any unique relationship established between hospital and shelter influence which facilities are used.

New York City has a wide range of public, low-cost medical care facilities including: City Department of Health child-health stations, tuberculosis chest x-ray centers, sexually transmitted disease-testing service, and Health and Hospital Corporation neighborhood family-care centers and hospitals. Additionally, special programs have been developed by various hospitals and other non-profit agencies. The medical care these programs provide is designed to take into consideration the special needs of homeless people. An example of this is a medical team that visits nearby shelters or soup kitchens to serve people there. Check with your shelter coordinator or screening site as to whether such an arrangement exists or could be established.

In some cases it may be better to work with voluntary hospitals and private doctors nearby rather than a public hospital far away. A closer location will make it easier for guests to keep appointments and for shelter staff to meet with health care providers. Some people have found that voluntary hospitals are less bureaucratic and easier to work with than public hospitals.

For some patients there is nowhere to go, so the place to go becomes the general hospital. It's a warm place, and we're open 24 hours a day.
—hospital administrator

Payment Considerations

One way hospitals differ from each other is in their financial structure. Public hospitals get tax money to cover costs not paid for by insurance. Voluntary hospitals (private and non-profit) are run on insurance payments, including Medicare and Medicaid. A limited amount of free care is usually provided.

Overall, it is difficult for anyone, homeless or not, to obtain medical care if they do not have insurance. Voluntary hospitals are generally more reluctant than public ones to treat people without insurance, Medicaid, or Medicare. (However, if the shelter is located close to a voluntary hospital, some sort of relationship may have been set up.) It is important to find out if a guest in need of medical attention has some type of insurance coverage before making any suggestions about his or her health care. In New York City, it is likely that Medicaid coverage is available or obtainable for most shelter guests.

If a guest is a veteran, he or she may be eligible to go to the Veterans Administration hospital (the VA). Perhaps the guest is eligible for Medicare. Some cities and states have special programs that will pay for medical care for certain types of conditions, such as prenatal care for women who have no other health insurance.

When a Guest Refuses Care

You will often encounter a guest with a medical problem who refuses care. It is troubling to see a treatable condition worsen from lack of care. Still, the guest whose judgment is not grossly clouded by a psychiatric condition ultimately has the decision-making power, and this right must be respected. Notify the coordinator if he or she is not aware of the guest's condition.

When trying to encourage a guest to accept needed care, the best approach is to show concern and provide support and understanding. Let the guest talk. There are many reasons for avoiding doctors: fear of being kept in a hospital; denial that anything is wrong; suspicion of doctors; needing more time to think about it; not considering one's illness as serious, or thinking it'll go away on its own. Most people have similar thoughts when ill or injured. Seek out the guest's particular reason for not wanting medical care. If, for instance, a guest dreads finding out what is wrong, a good approach would be to remind the person of the opportunity to discover that it's *not* something serious. If the problem is fear of the unknown, perhaps the guest will be reassured by knowing exactly what to expect. Try to leave plenty of room for the resistant guest to change his or her mind in the future. Health issues can be very emotional and may take time to resolve. Too often homeless people are rushed and processed through medical procedures with little regard for their feelings or sense of autonomy. You are in a unique position to take the time with a guest on such issues.

Of course, if a guest continues to refuse medical care despite deteriorating to a point of endangering him or herself, you should talk to the coordinator about the possibility of psychiatric intervention. Allowing a treatable illness to progress to the point where one's life is in danger is similar to suicide, and the steps listed in Chapter 3 regarding suicide may be appropriate.

EMERGENCY SITUATIONS

Any condition that is life-threatening to a person is considered an emergency. This determination rests mostly with the person who is physically closest to the stricken individual, and he or she should be empowered to make the decision to call 911. Even if the emergency turns out to be not as serious as first believed, it is better to call and let the skilled specialists advise you. They are trained in first aid and emergency care. Let 911 advise you.

The following two examples of medical emergencies show when dialing 911 would be appropriate. The guest may have a combination of some of the following symptoms, and if the condition seems to be dangerous it should be considered an emergency:

Example A

- Shortness of breath
- Muscular weakness
- Blue tinge to light-skinned people; nail beds and lips an ashen tone in people wih dark skin
- Heavy sweating
- Chest pains that are severe, crushing, constant, and lasting for several minutes. Pain may radiate to arm, should, neck, jaw, mid-back, or stomach.
- Anxiety and fear
- Nausea or vomiting
- Pulse rate at the extremes (below 60 or above 100 beats per minute) and very weak

Example B

- Breathing is irregular, noisy, and rapid
- Lack of responsiveness, partial or full loss of consciousness

- Blue tinge to light-skinned people; nail beds and lips an ashen tone in people with dark skin
- Skin is cold and clammy
- Confusion and anxiety
- Nausea and vomiting
- Unusual thirst
- Pulse is weak and rapid (more than 100 beats per minute)

The technician who answers the phone for 911 is in contact with a physician if needed (as are ambulance crews). When in doubt about a seemingly serious condition, *use the expertise available at 911.*

Calling 911 For the Emergency Medical Team

In an emergency, one person taking control and directing the situation will have a calming effect. One volunteer, for instance, should complete the telephone call and then return to talk with the patient and other guests and volunteers. A second volunteer (or trusted guest) should stay with the patient. Try to remain calm. Panic is contagious and may aggravate the situation.

Your call will be answered by a police department operator who will transfer the call to an Emergency Medical Service (EMS) Technician. He or she will ask a number of questions about the emergency and advise you on what to do.

Make a note of the time of your call and be prepared to give the following information:

- Where—state the address and cross street and directions for which entrance to use. Give the name of the church or synagogue if that is where the shelter is located, along with the number of the telephone you are using.
- Who—such as "elderly male" or other appropriate description.
- What is wrong—the person is barely breathing, unconscious, etc.
- What, if anything, is being done for the patient. Find out if anyone nearby has had CPR or emergency training. Ask if anything could or should be done while awaiting an ambulance. The EMS technician will sometimes give medical instructions over the phone. You will want the most qualified person to work with the EMS technician.

Write down the name or identification number of the EMS technician. Ask for an estimated time of arrival for the ambulance. Hang up last, letting the EMS technician conclude the call. Check the time. If the ambulance has not arrived within the expected time, call 911 back.

It is important to take the time to answer all questions. The technician needs to know whether to send an ambulance with specialized equipment, and must determine where the patient should be taken, such as a specialized cardiac-care or burn unit. Despite the urgency of the situation, do not try to skip this step.

Waiting For the Ambulance

Ask one or more of the guests to wait by the building entrance to motion to the ambulance when it is sighted. The volunteer staying with the victim should take one or more of the following steps:

Discourage Spectators From Gathering. Be as considerate of the guest as possible during this very frightening time. Keeping the area quiet will have a calming effect. Protect him or her from unnecessary disturbances.

Tell the Guest What You Are Doing. Reassure the guest that help is on the way. Encourage the guest to stay still and not move.

Check General Appearance. Look for signs of injury or illness, such as bleeding, skin color, or burns. Try to figure out (not necessarily by asking questions) what happened and how the guest is feeling. Note mental states to see if the guest is awake, confused, stuporous, or unconscious.

Loosen Clothing. Do this if it seems to be uncomfortable. Check for an emergency identification bracelet, or medical card. Information about medical problems, allergies, or medication is useful for the emergency medical team.

Provide a Blanket if Needed. Do not give liquids or food unless the medical team has instructed you to do so. Under no circumstances is alcohol to be given.

Check Breathing Constantly. This has highest priority. If the guest is unconscious, keep checking his or her breathing by feeling for the rise and fall of the chest, or listening for air coming out of the nose and mouth. If the condition worsens (for example, breathing stops), it may be best to call 911 back to get further advice from the EMS technician.

Provide Emotional Support. Do not talk about the person in front of him or her, if possible. Try to provide whatever emotional support the guest is able to accept. Pay close attention to the person's feelings and reactions during this time. Touching the person or holding his or her hand may be a very comforting gesture.

When the ambulance has taken the person safely away, make sure appropriate people have been notified (the screening site, the shelter coordinator, etc.).

If Breathing Stops

If you determine that a guest is no longer breathing while waiting for an ambulance, these are some steps a person trained in mouth-to-mouth breathing will take. If you are not trained in CPR follow the directions of the EMS technician at 911. The steps below are listed only to provide some familiarity with the technique.

1. Loosen constrictive clothing and clear the mouth.

2. If possible, lay the guest on his or her back.

3. If possible, remove dentures, blood, debris, etc. Turn head to side to do this.

4. Tilt head backward—chin should be highest point on face. Support the back of the head with one hand. The nostrils should be pointing upward. Breathing may start naturally in this position.

5. Administer mouth-to-mouth breathing. Pinch nostrils together. Seal your lips around the guest's open mouth to prevent the escape of air. Blow forceably into person's mouth *slowly.* Allow deflation. If breathing is not resumed, repeat mouth-to-mouth, giving one breath every five seconds, twelve breaths per minute. Continue, maintaining a rhythm, until the guest can breathe on his or her own. Have another worker take over if necessary.

NOTE: For people reluctant to do mouth-to-mouth breathing for their own health safety, a handkerchief or other fabric may be placed over the guest's mouth as a barrier.

If a Guest Has an Epileptic Seizure

Symptoms of epileptic seizures vary from person to person. Some are minor attacks characterized by fixed, staring eyes and pale skin. Some seizures are preceded by an aura, which is a warning sign that alerts the person a seizure is imminent. Some people give no warning at all.

During a major epileptic attack, a guest may become unconscious, fall to the ground, and have uncontrollable, jerky movements of all extemities. Muscle spasms occur, including the respiratory muscles. This might cause the guest to turn blue. A guest is unable to swallow during a seizure causing the buildup of saliva, and foaming in and about the mouth.

During the seizure, the guest may lose control of bladder and bowel functions. After a seizure subsides, there is a brief phase of unresponsiveness, followed by confusion and then fatigue.

If a guest has a seizure, it is most important to prevent injury to the person. Don't panic. Volunteers who have little experience with seizures can always rely on 911 for guidance.

- Protect the guest from injury. Lower him or her gently to the floor. Remove any objects, such as chairs, which may cause injury.
- Do not interfere with convulsive movements by restraining the guest. You may cause injury. Let the seizure run its course.
- Do not attempt to force anything between the teeth or into the mouth during the seizure.
- Loosen constrictive clothing.
- Do not attempt to give fluids or to throw water on the guest's face.
- Be sure the guest has an open airway and that breathing resumes after the seizure subsides.
- If needed, gently turn the head to the side to allow drainage of fluid from the mouth.
- When consciousness is regained, you can aid the guest's re-orientation by saying who you are, what time it is, and where he or she is. Stay with the guest awhile to help allay anxiety and confusion. The guest will feel fatigued and need to rest.
- Watch for increased respiratory difficulty, shift in intensity or site of pain, color of skin, or anything else that may be helpful if further medical attention is needed.

- Medical attention should be obtained promptly if another seizure occurs, if the guest is pregnant, or if injuries have occurred as a result of the seizure.

PREPARING FOR EMERGENCIES

For smooth referrals, the following information should be readily accessible:

- Emergency telephone numbers
- Neighborhood medical resources
- Shelter protocol for emergency situations

The following checklist of First Aid Kit supplies is for volunteers or workers with only introductory training in handling medical emergencies. If someone on the premises has been trained in First Aid (and this is highly recommended), supplies may be upgraded for their use. Volunteers, however, are usually not doctors and are not expected to treat illnesses. The best policy is to learn how and where to get the most qualified medical care for the guests whenever possible, rather than to do it yourself.

FIRST AID KIT CHECKLIST

___ Sterile gauze pads (4×4)
___ Gauze dressing (10×9)
___ Four rolls of 3" gauze bandages
___ White adhesive medical tape (1")
___ Band-Aids
___ Elastic bandages (3")
___ Scissors
___ Sterile absorbent pads
___ Triangular bandages
___ Safety pins
___ Tweezers
___ Cotton swabs
___ Plastic measuring cup
___ Ammonia ampoules
___ Hydrogen peroxide
___ Soap (mild)
___ Handkerchiefs
___ Pencil and pad
___ Small flashlight
___ Sterile tongue depressors
___ Oral thermometers
___ Small jar of petroleum jelly
___ Disposable plastic gloves
___ Sterile alcohol pads

In addition, every shelter should have:

- A fire extinguisher in an accessible place.
- A bucket, mop, and a bottle of household liquid bleach (for disinfecting).
- A copy of the poster describing first aid to choking victims (available at the New York City Department of Health, 125 Worth Street, Room 144, New York, NY 10013, weekdays, from 8:30 A.M. to 5:00 P.M.).

COMMUNICABLE CONDITIONS

To decrease the likelihood of disease in the shelter, follow proper handwashing procedures and use disposable paper products.

Handwashing should occur before handling or preparing food, before eating, before and after using the bathroom, after handling soiled articles, before and after assisting a guest with a medical check or procedure, after delousing a guest, or after performing any other personal hygiene measures.

Other preventative measures include:

- Use disposable tissues and paper towels for volunteers and guests.
- Use plastic utensils, paper plates, and cups.
- Discourage sharing eating or drinking utensils, food, and cigarettes.
- Discourage sharing clothing, towels, bedding, combs, or hairbrushes.
- Do *not* allow guests suspected of, or known to have, communicable conditions to participate in food preparation or handling.
- Use disposable plastic gloves and a solution of water and liquid bleach in a ratio of 10:1 to clean spills of blood, urine, or vomit.

In the event of a seemingly serious illness or contagious condition, such as jaundice or lice infestation, definitely notify the shelter coordinator or any other appropriate staff person. Contagious illnesses listed in this section must not go unattended in shelters for the safety of the other guests.

Lice

Everyone who works with homeless people worries about catching lice at some time. However, with proper precautions the risk is minimal. If a worker is screening for, or treating, lice or scabies (a similar parasite that burrows under the skin), he or she should wear disposable plastic gloves and wash hands thoroughly when finished. These infestations are spread mostly by direct contact or by sharing infected clothing, bedding, and combs. *Lice do not jump or fly.* They need a human host to survive, but will live for a day or more in sheets or clothing. Effective delousing requires the use of a medication with a pesticide, a fine-toothed comb, a shower, and a complete change of clothing. Brand names of effective over-the-counter medications are RID, A-200, and R&C. Kwell is the brand name of the pesticide often prescribed by physicians. Even when properly used, Kwell is reported to have toxic side effects on some people. Not all

guests are familiar with these products: stress that such products are for external use *only*. Leave Kwell on the skin no longer than 10 minutes; 15 for nonprescription medications. When using any of these preparations, please take precautions so that excessive quantities are not used and make sure the manufacturer's directions about repeated applications are followed. For further information, the following pamphlet is recommended: "Lice and Scabies from Infestation to Disinfestation," Reed and Carnrick, Piscataway, NJ 08854.

Tuberculosis (TB)

This disease mainly affects the lungs. It is sometimes characterized by coughing, weight-loss, fatigue, and fever. These symptoms also accompany colds, bronchitis, and other common illnesses among homeless people. Tuberculosis is spread by droplets, tiny particles that remain in the air after an infected person coughs. If these droplets are inhaled at once (the germs die soon after leaving the body) by another person, it is possible that germs might be transmitted. Be aware that although TB is a concern for shelter staff and guests, the chances of contracting TB from a guest are actually rather small. Adequate ventilation and sunlight (ultraviolet rays) greatly decrease your risk, as does maintaining good health and hygiene.

Hepatitis

This is an inflammation of the liver that may be due to several causes, such as alcohol abuse or a viral infection. The infected person's eyes and skin may have a yellow color called jaundice. Type A (infectious hepatitis) is caused by a virus shed into body wastes and can be transmitted to a person's hands. Proper handwashing is very important. Type B (hepatitis B) is transferred by blood, through the sharing of needles, or by sexual contact. It is not transmitted by day-to-day contacts. Any guest who is jaundiced should be evaluated at a medical facility to determine the cause. Prevent the spread of hepatitis by: (1) not sharing eating or drinking utensils, and (2) careful handwashing before eating, and after using the bathroom.

Acquired Immune Deficiency Syndrome

AIDS, or SIDA in Spanish, is the result of the immune system's inability to resist certain types of infections or cancers that rarely pose a threat to persons with a normally working immune system. Researchers have discovered the HIV (HTLV-III/LAV) virus and linked it with AIDS. It can be transmitted by these specific activities: sexual intercourse; sharing an infected hypodermic needle; or, less often, through exchange of blood or blood products. Unlike other communicable diseases, AIDS is *not* highly contagious. Since there is no evidence that AIDS is spread through casual social contact, not even among family members or caretakers of AIDS victims, there's no reason to avoid any public or private place as a prevention. In New York City the AIDS Hotline, 718-485-8111, provides information and answers questions Monday through Saturday from 9 A.M. to 9 P.M. The New York State Department of Health provides tape recorded information about AIDS, plus referrals throughout New York state. Call 800-462-1884 daily from 8 A.M. to 8 P.M., except Sundays and Saturdays, 10 A.M. to 6 P.M. Ask for English tape #59 or Spanish tape #61.

ADDITIONAL RESOURCES

For more detailed medical information, the following books are recommended:

Health Care of Homeless People. Edited by Philip W. Brickner, Linda K. Scharer, Barbara Conanan, Alexander Elvy, and Marianne Saverese. United Hospital Fund, Springer: NY, 1985;

The Shelter Workers Handbook: A Guide for Identifying and Meeting the Health Needs of Homeless People. Produced by the Health Committee of the Coalition for the Homeless, 105 East 22nd Street, New York, NY 10010. 1984;

Standard First Aid Book of the American Red Cross, 150 Amsterdam Avenue, New York, NY 10023. 212-787-1000. Courses on CPR (cardiopulmonary resuscitation) and first aid are available to groups and individuals from the Red Cross.

SUMMARY

We hope the preceding information has helped you to understand and appreciate the problems of homeless people affected by disease. As you become more familiar with your guests, you will find that the life of a homeless person takes its toll on the body. Chapter 8, Entitlements, will help you better understand the various government agencies and programs that provide health services for homeless people. Use the information there to guide you when dealing with a guest who is ill.

Chapter 6

Preventing and Managing Conflict

Anybody who's down and on the streets has got hostility in them. They gotta let it out somehow . . .

—former city shelter resident

The daily lives of homeless people are sometimes filled with frustrations, tension, and weariness. At the end of the day, when one needs private time to relax and recuperate, the guest in an overnight shelter has to cope with the uncertainty of bed assignments, transportation logistics, and the moods and habits of other people crowded together for the night. In general, you should anticipate occasional outbursts of temper, and be willing to help the guests ease their tensions. Among any group of people amassed in a shelter, irritation and conflict must be expected.

UNDERSTANDING CONFLICTS

Because our response to conflict situations is usually negative—fear, anger, frustration, or guilt—conflict is often considered a negative force that should be avoided or suppressed. However, while conflict situations may be unnerving, they can also be viewed as a positive fact of life with the potential of bringing about change and growth within the shelter environment.

Interpersonal conflict occurs when two or more people have incompatible goals or expectations, have differences in values, or engage in incompatible activities.

Such interactions can take the form of tension, limited communication or withdrawal, potentially violent arguments, or physical fighting. In shelter and meal programs, conflict among guests may be seen in rule-breaking, angry outbursts and/or fighting, or challenging behavior. Stubbornness, jealousy, racism, sexual tensions, cultural clashes, and competitiveness—all elements of our society at large—exist in the shelter community as well.

Some guests perceive the world as a violent place, and therefore little provocation is needed for them to react in an explosive or threatening manner. Often, their negative perception of the world is based on a personal reality. Such a background may lead to an inaccurate perception of the intentions and actions of others.

Suppose you pick up a guest's jacket with the intent of hanging it up, and the guest surprises you by grabbing the jacket back, shouting, "Keep your hands off that!"

The guest is in fact wise to keep an eye on his or her property and has, perhaps, behaved according to his or her outside life. But the reaction may be far too strong and is inappropriate in this particular situation. This sort of conflict can be used by an alert volunteer to help the guest re-evaluate survival or defensive behaviors that do not adapt well to new situations. Both the guest and the volunteer may begin to learn new ways.

TENSION BUILD-UP AND CONFLICT

A buildup of tension almost always precedes a conflict between two people. The rising tension level is often recognizable in its early stages and, if redirected, some conflicts can be avoided. Extreme tension and stress are common among people in shelters. Sometimes you can assist individual guests to ease their personal tensions, but more frequently you should try to reduce the further buildup of tension in the shelter.

To prevent tension buildup, identify the tension centers in your program. By "tension centers," we mean those areas or elements of the program that regularly cause tension or controversy among guests or between guests and staff. Some examples are:

- Waiting time for meals or for use of the bathroom.
- Bed assignments, or the loss of privacy when another person sits on a guest's "own" bed.

- Noise level, as when one guest plays music too loudly (or sings, talks, hums, etc.).
- Exit time in the morning when guests have nowhere else to go. This is also a high stress point for volunteers, who may contribute unintentionally to the tension level.

- The appearance of, or actual instances of, special favors or privileges for some guests and not others.
- Ongoing conflict between regular guests who do not get along.

In addition, there are tension times just before holidays, in extremely hot or cold weather, and when public assistance payments are delayed. Because volunteers in some programs spend only one night a month with shelter guests, it is important to let the coordinator know about any guest's behavior or parts of the shelter program that seem to contribute to the tension level.

How to Manage Sources of Tension

Where possible, attempt to solve or relieve one or more of the central problems. This could mean involving staff and guests in a problem-solving meeting

about how to coordinate mealtimes, for example. Sometimes the problem cannot be solved, but acknowledging the problem and including others in work on it can relieve some of the negative feelings it causes.

Set clear rules and procedures for shelter operations, including conduct and behavior that is unacceptable. These need to be known by all staff, volunteers, and guests, and applied consistently. When an exception is made, explain it to avoid the appearance of favoritism.

Identify guests who precipitate or aggravate tense situations. Try to separate or isolate them from tension centers at critical moments. Be sure to let the coordinator know about any difficulties or tense circumstances that occur, so the coordinator may be aware of the guests' behavior over time.

Allocate well-defined roles and tasks for guests, staff, and volunteers as they participate in activities. Whatever can be done *beforehand* to avoid misunderstandings of expectations or behavior reduces confusion and discomfort.

Know your limitations. Understand that stressful situations may occur when guests expect or demand more than you can give. ("Why can't you place me at this shelter every night? I know you can!").

Coping with Guests who Create Tension

Recognize that the guest's days have likely been filled with aggravations and that part of your task is to help relax an agitated guest. Empathize, listen, and do your best to understand the guest's perspective and situation. Of course, this is not as easy as it sounds, especially when the guest directs anger at you. It helps to remember that all of us have the capacity to say unfair things and act unreasonably when angered. Here are some useful ways to work toward the easing of tension:

- If possible, avoid waiting for the guest to work up to an outburst. Spend a few minutes to find out what's bothering the guest: "You seem very quiet tonight. Had a rough day?" Empathize with the setbacks. Perhaps you can offer more positive or fruitful responses to the problem than the guest is considering.
- Set out specific expectations and boundaries by defining the scene before the upset guest does. This means letting the guest know how to act, and can be done in two ways: individual guests can be advised about the climate, structure, and activities at the shelter, along with introductions if needed. Or a short nightly meeting with all guests and staff can be held and used to introduce new guests to old ones; explain the roles of different guests and volunteers; talk about why the shelter is there, the type

of attitude that prevails and how the sponsors would like the shelter to be used by guests; recognize the difficulties that may have been experienced during the day; and discuss rules and routines.

- State limits clearly, and give reasons. Explain to the agitated guest that, for example, it's all right to be angry or upset, but it is not acceptable to shout [*the rule*] and disturb other people who have come in from the streets to rest [*the reason*].
- Separate an agitated guest from other tension producers.
- Help the person to focus on a concrete activity.

YOUR PERSONAL STYLE

Each shelter volunteer or worker needs to be aware of his or her particular style of dealing with a conflict situation, and the potential impact of that style on the people involved. Each of us has an individual personality, style, background (including your age, race, sex, and overall appearance), and set of skills which suit some situations and guests better than others. It will be useful to be aware of not only your own style, but your co-workers' as well.

Your awareness of different kinds of responses to a conflict situation will allow you to gain control of a personal style that might have a negative effect. Some people's response to a tense situation might be panic and immobility while another person might be able to use humor very effectively. An individual may become especially enraged and disgusted with an intoxicated person. Others could be much better at handling a particular crisis.

This should not be seen as a failure on your part, but, rather, a wise assessment of your strengths and limitations. The volunteer who is objective about his or her skills ("Your friend Mr. R. and I don't get along all that well—I'll take over what you're doing if you'll go calm him down.") is ultimately more valuable in the teamwork setting of most shelters.

PREVENTIVE MEASURES

Again, it is rare in small overnight shelters for serious conflict situations to arise, but it is best to be prepared for any sort of situation. Find out the shelter rules. You are not expected to make important decisions on your own without preparation.

Once you know the shelter rules and policy, it is a good idea to develop contingency plans for the evening or shift. For instance, when two volunteers are on duty at an overnight shelter, they should always know each other's whereabouts: "I'm going to make a quick phone call—be back in two minutes."

Another important practice is that at least one person remain with the guests as much as possible. It would be unfortunate if an argument broke out or an accident occurred when no one was in the room. Remember, you are working together as a team.

Volunteers will want to maintain a mental list, if not a written one, of backups in the event of an emergency. For a single person staying alone in an overnight shelter, the line of backup might be: (1) the shelter coordinator if time permits a phone call; (2) a trusted shelter guest; (3) the building superintendent; or (4) in the most extreme case, dialing 911 for an ambulance or police car. Two volunteers in another shelter might have as a backup: (1) the other volunteer; (2) a security guard; (3) making a phone call to the coordinator if time permits; (4) trusted guests; or (5) dialing 911.

If you are unclear about who to rely on for help, talk it over with the shelter coordinator. Also, please note that it is very important for a telephone and important telephone numbers to be easily accessible.

Helping to Resolve Arguments

When you approach angry guests who are about to fight, it is important to move slowly and with open hands. Angry people anticipate forceful reactions, and you must make it clear that it is not your intention to harm the guest.

Secondly, regardless of how afraid or angry you may feel inside, you should try to give the outward appearance of being calm. If you appear to be afraid of someone who's angry, the guest may react to the sense of danger and act accordingly.

Guidelines for Resolving Arguments

Operate as a Team. By doing so you'll already be diffusing the scene.

Take The Lead in Resolving the Dispute. Whoever has the better relationship with the guest(s) involved should take the lead. Or whoever is seen as the most respected staff figure by the guest(s) should begin.

Separate Guests as Quickly as Possible. Allow them to ventilate (let off steam) away from each other. Ventilation is only dangerous when two people do it at each other, which can escalate the conflict. Make sure that each guest gets a chance to save face by telling his or her side of the story. Don't assume that the argument will fade away simply by separating the guests. It may stop temporarily, but unless issues are discussed, the disagreement will soon continue.

Ask Only Open-Ended Questions. These questions allow the guest to respond with an explanation of his or her choice rather than just a "yes" or "no" to your question. Avoid blunt, demanding questions. Rather than saying, "Why did you hit her?" a better start might be, "Mary, what's the matter? What's going on that you're so upset?"

Set Firm Limits and Be Consistent. "You have a right to feel angry, but you should not shout while you're in this room."

Try To Understand the Guest's Point of View. Understanding someone's point of view is not the same as agreeing with it.

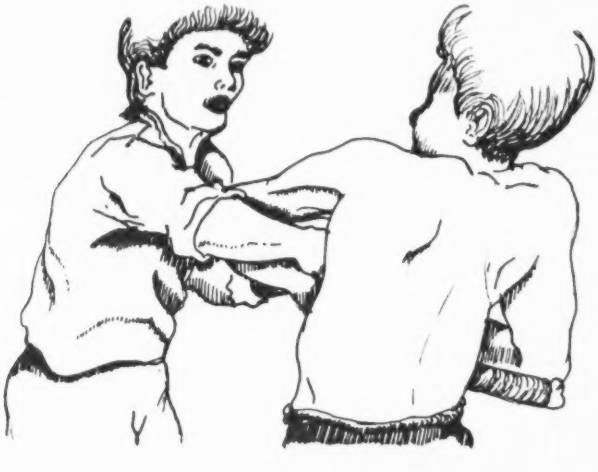
Focus on Interest, Not Positions. A *position* is what someone has decided to do (*e.g.*, to open or close a window). An *interest* is what caused the person to decide on the position (to get fresh air or to avoid a cold draft). Conflicts based upon interests can be much more easily negotiated and accommodated than can those based upon positions.

One way to focus on interests is to point out common interests between opposing parties ("Both of you want to have peace and quiet so you can rest tonight. We don't want to create noise and bad feelings here, right?").

The goal in trying to resolve a conflict is to find a way for the participants to agree on behavior that is acceptable to each other. The guest who believes you understand his or her feelings is more likely to try to understand how others feel.

Breaking Up a Physical Fight

Fights between guests do not happen frequently, but are a source of alarm and fright for volunteers and other guests. With the responsibility to keep order in the shelter and to protect guests, you might run a real risk of getting hurt in the process. Before intervening, and if time permits, try something else: attempt to distract the participants verbally, each volunteer focusing on a fighter



and talking to him or her one-on-one. Once again, you may wish to restate very firm limits and rules clearly: "You cannot fight in here. If you don't stop at once, you'll have to leave." Or " . . . We'll have to call the police," and then direct another volunteer to do so. The prime objective is to avoid injury—including *your own.*

Of course, it helps to be very familiar with your shelter's policy or recommendations regarding physical fights. Calling 911 is generally recommended when there seems to be any danger of people being hurt. If you do decide to intervene physically, the goal shouldn't be to restrain, but only to separate. Don't push, kick, or hold the person down in any way. Your only goal is to separate.

Follow the guidelines for resolving an argument once the fight has ceased and the guests are separated. Allow plenty of time for the guests to calm down and to talk about their feelings.

SUMMARY

Trying to resolve conflict situations accounts for a great deal of the stress and "burn out" among volunteers and staff. It can take several days to recover emotionally from involvement in a fight. You need both support in deciding how to prevent and handle disputes, and emotional support for handling your feelings after the incident.

Group meetings of staff and volunteers, and clear guidelines for handling these situations are helpful. Remember, too, that the other guests are as deeply affected by disruptive outbreaks as you are. It will be useful to discuss feelings and provide an opportunity to share thoughts. It is as important to provide a feeling of safety as it is to actually provide safety to the guests.

While tension is inevitable in the often crowded conditions of the shelter, potentially harmful confrontations are relatively rare occurences. As you and the shelter coordinator or other staff learn more about your guests and refine your roles, you'll find that managing what can be a pressure-laden situation will become easier.

The following chapter on advocacy explores the role of a volunteer who wishes to become further involved in helping guests. It will guide you in deciding when and how you can help your guests toward getting much needed services and entitlements.

Chapter 7

Advocacy

Your first instinct is to tell them what to do.
You want to help and you see things your way,
so you start pushing them in that direction.
But it doesn't work that way—it's their life
and their perspective is different from yours.

—shelter volunteer

Anyone working with homeless people is constantly aware of the lack or limited availability of services and housing for guests. Whether you are volunteering in an overnight shelter that provides a meal and a bed, or working in a more comprehensive agency that attempts to provide a range of support services, you will soon become aware of the need to join with guests to help them meet basic needs.

Advocacy means to "speak out" on behalf of another person. An advocate is generally more familiar with an area—law medicine, or finance—than the person using the service. Lawyers, for example, are advocates when they represent clients in court. However, one does not need to be a professional to perform many types of advocacy for shelter guests.

There are two broad categories of advocacy in which you can be involved: case and class.

Case Advocacy. This refers to assisting an individual in obtaining his or her rights under the law. The focus tends to be on short-term issues, such as help-

ing a shelter guest get the public assistance to which he or she may be legally entitled. In a limited way, case advocacy may simply mean making telephone calls on behalf of a person or explaining a guest's needs to the shelter coordinator.

Class Advocacy. This usually involves action on behalf of a group to change the way it is being dealt with as a whole. It usually involves systematic long-term change. Class advocacy includes legal efforts to change shelter policy regarding homeless youths, or organizations for the disabled taking action to protect wheelchair-bound homeless peoples' rights to enter shelters. It may involve urging government officials to support creation of low-cost housing. In New York City, one group that focuses on class advocacy issues pertaining to homeless people, including class-action lawsuits, is the Coalition for the Homeless located at 105 East 22nd Street, New York, NY 10010. You may request to be put on the mailing list to receive notification in the newsletter *Safety Network* of monthly meetings.

The strategies used and the resources required for both types of advocacy are different. At a small church- or synagogue-based shelter with limited contact between guests and volunteers, advocacy may involve only a small number of individual case efforts. For other programs, usually those with full-time staff and more opportunity for intervention on behalf of guests, advocacy may be a major tool.

Keep in mind that benefits and entitlements for homeless people are limited. It is most appropriate to seek services and public entitlements, such as housing or welfare. But the potential advocate should also keep in mind that advocacy efforts will be constrained by what is realistically available. Don't further distress a guest by promising more than you can deliver as an advocate.

THE ADVOCATE'S ROLE

An advocate represents a guest's interest, and it is the *guest* who should define those interests. The advocate may help to give shape and substance to those interests, but must always be sensitive to certain guests' attitudes. For instance, a guest may feel that a person should be ashamed of needing public benefits. An experienced advocate recognizes negative attitudes and feelings and makes sure that guests know that public benefits, such as Food Stamps and Medicaid, are not charity, but an "entitlement," guaranteed by law.

The advocate should be aware of the effect his or her behavior and attitudes has on the guest, in order to avoid patronizing behavior or actions that exclude the guest.

Just because you helped me to get my money straightened out, don't think you can tell me what to do with it. My check doesn't come with your name on it.

—guest to caseworker

Be prepared to respond to a broad range of needs, in addition to specific requests for assistance. You should be able to refer clients to other services for which they might be eligible.

When a guest's problems are outside your expertise, the guest should be referred to an organization better equipped to handle the problem, if possible. If a referral is made, follow it up to be sure that the client's needs are met.

Guests have the right to expect aggressive advocacy on their behalf. It is important, however, to be calm and reasonable and to know the facts. Negotiations on behalf of a guest should be conducted in a courteous manner. Feelings of anger and frustration are best exposed diplomatically and *gradually* when dealing with administrative agencies such as the Food Stamp program or the Social Security Administration.

The above was adapted from *An Advocate's Guide to the Food Program in New York State,* Community Action for Legal Services.

Advocacy takes many forms. Examples of advocacy activities might include: negotiating with hospitals or mental health services on a guest's behalf; defending the shelter's right to exist in the community; and protesting a guest's treatment by another program or shelter.

Both class and case advocacy require research, networking, strategy, coordination, follow-up, documentation, and persistence. You will, in time, learn the most effective routes to take with guests in order to solve problems. Sometimes community organization and political pressure is the most effective way. Other times, carefully documented information presented to a decision-maker will work. Seeking out other organizations or coalitions that share similar concerns often strengthens a group's position on an issue.

ADVOCACY TOOLS

Some of the key tools you will employ as an advocate are discussed below.

Ability to Negotiate. Developing sharp negotiation skills is invaluable if you wish to represent guests effectively and assist them in securing their rights and benefits.

Create and Maintain Records. The homeless guest will probably not have a telephone, a desk, extra paper, or a safe storage space. He or she may have other pressing needs that make paperwork less of a priority. ***Write everything down*** when advocating on behalf of a guest: date, time, telephone numbers, names, etc. Documenting even the number of times you call a busy number might prove to be valuable evidence (inconvenience and inaccessability to services are serious matters) when solving a problem or promoting improvements.

Understanding of the Guests' Needs. As an individual or group advocating on behalf of the homeless, your use of your guests' perspectives, needs, and suggested solutions is the key to making you an effective advocate. After all, you function is to represent the guests' interests.

Knowledge of the Systems and the People Who Govern. Whether the systems be legal or political, it is important that the advocate is knowledgeable or has access to information about whom to contact.

Having a Range of Resources. Besides shelter, there are also a variety of other immediate and long-term needs that require creative use of an array of resources on the part of the advocate.

Philosophical Perspective. Not every person shares the view that homeless individuals are entitled to quality services and that the government has the responsibility to lead the way in ensuring these services; as an advocate for the homeless you *do.* You believe in treating the homeless with respect and allowing them to retain or regain their dignity as human beings. This perspective greatly influences the content and approach of the services you provide the homeless.

Know Your Limitations. It is important to know your individual and organizational limitations. Do not promise what you cannot deliver. This creates cynicism and lack of trust in the guest toward volunteers and people in the helping professions. As an advocate, it is your responsibility to know other resources that complement or extend beyond your limits and to make this information available to guests. If nothing exists beyond your limits except the guests' needs, it is your responsibility and your guests' to become involved in broader advocacy that will expand the system's resources.

SUMMARY

As has been stressed throughout this book, the role of the volunteer or staff person is to *help* the guest make his or her life better. The temptation to promise too much might be there, but know your own boundaries and limits. There's nothing wrong with admitting your own lack of expertise or lack of time when dealing with some of the problems of homelessness. If you are so inclined, advocacy on a political level might prove a rewarding experience.

The next chapter, Entitlements, will provide you with new information on how you can help your guests receive the benefits to which they are legally entitled.

Chapter 8
Entitlements

"Entitlements" is a general term used to describe a wide range of benefits, either income or services, to which people are entitled by law. Various government agencies administer and finance programs such as Public Assistance, Social Security, Supplemental Security Income, and Food Stamps.

Each of these programs has a legal basis as well as numerous regulations administered by complex bureaucracies. Some entitlement programs, such as Public Assistance and Food Stamps, may be available to poor people whether they are disabled or not. Other programs, such as Social Security Disability and SSI, are restricted to the blind, the elderly, and those considered physically or mentally disabled.

Guests at shelters and soup kitchens often approach volunteers for help in applying for, finding out about, or solving problems with such programs. While much of the information on this topic has been written for lawyers and other

advocates who assist the poor with entitlement problems, it is possible for a part-time volunteer to gain sufficient knowledge to be of assistance. This chapter contains an overview and introductory material on entitlements for volunteers or workers who may become involved with this aspect of their guests' needs.

ENTITLEMENT PROGRAMS OVERVIEW

Public Assistance. Public assistance, or welfare, is available to citizens who are determined to be without sufficient resources to maintain themselves. Two major categories of assistance exist: (1) Aid to Families with Dependent Children (AFDC) and (2) Home Relief (HR). These programs are means tested—only those with no income or very little income and little or no savings are eligible.

Supplemental Security Income (SSI) This is paid to persons who are elderly, blind, or disabled, *and* poor.

Social Security Disability Benefits (SSD) These benefits are available to blind or disabled persons and their dependents (in some circumstances) if the person worked for a sufficient period in covered employment, usually 10 years or 40 quarters. Some persons who become disabled prior to the age of 22 and some disabled widows and widowers of workers insured at death may also be eligible for this benefit.

Social Security Survivors Benefits. These are available to certain members of a deceased insured worker's family, such as dependent children, widows, or widowers aged 60 or older, divorced spouses aged 60 or older (under some circumstances), and dependent parents aged 62 or older.

Social Security Retirement Benefits. These are available to persons aged 62 or older who worked for a sufficient period in covered employment.

Worker's Compensation. This is paid to those injured in the course of their work, if the job was in covered employment.

Unemployment Insurance. This is paid to those who lose a job through no fault of their own, worked in a covered job for a sufficient period of time, and are actively looking for work.

Veteran's Benefits. These are based on military service, disability, and financial need.

HELPING A GUEST OBTAIN BENEFITS

A volunteer wishing to assist a guest with benefits should begin by finding out the guest's status: Does the guest have a caseworker who has any of the necessary papers? Is another person working on entitlements for the guest in any way? The route to gaining entitlements involves a lot of time and paperwork in most cases, so you will not want to duplicate steps already taken.

Loss of Entitlements

Documents used to determine eligibility are often lost when a person is homeless. This can happen for a number of reasons. Letters mailed requesting information or a recertification interview may have been delivered late, or not at all. Appointments could have been missed due to lack of transportation, illness, conflicting appointments, or other causes. A recertification interview is a periodic review of continuing eligibility, and if a person misses this appointment, he or she may be dropped from the rolls. A person who lives on the streets, is distracted by the demands of raising small children, or has a drinking problem, may forget appointments. He or she might believe that appearing late will have the same result as not appearing at all, which is not true in many cases.

If you understand the difficulties and discouragement experienced by homeless people dealing with bureaucratic agencies you can provide empathy, support, and sensitivity when helping a guest through what may be a complicated process. Staff in many agencies carry huge caseloads and are unable to spend enough time with individual clients to provide needed help in establishing eligibility.

Helping the Guest with Preparation

There are several things you can do to help a guest get ready to make an application for financial assistance:

Help the guest organize documents, making certain that a copy of each is kept. It may be necessary to send for documents, such as a birth certificate. You can help write letters and make phone calls.

Help the guest make a list of things he or she wants to remember, such as the name and telephone number of the caseworker to be seen, or a reminder to request expedited food stamps.

Find out about the application process and pass that information on to the guest. Help him or her know what to expect.

Whenever possible provide directions, carfare, lunch, envelopes, and a pen. If needed, you may accompany the guest.

Give moral support. Having another person share in accomplishing or not accomplishing a goal can make a big difference.

ELIGIBILITY

Various entitlement programs have different requirements for determining eligibility. In this next section, we will look into specific entitlement programs.

Public Assistance

Public Assistance (PA), welfare, Income Maintenance (IM), Aid for Families with Dependent Children (AFDC), and home relief (HR) are all terms describing the same program. Eligibility is determined by an examination of income, resources, family size, and living arrangements of the person making application. Each application is reviewed individually. Receipt of a small income from any source does not mean an applicant will be ineligible.

In New York City there are 40 income maintenance centers (welfare offices). To locate the correct center, call 212-925-4665.

Shelter Eligibility. Persons staying in city-operated shelters for individuals, overnight shelters sponsored by the Partnership for the Homeless, and private shelters are eligible for public assistance. The monthly public assistance grant for residents of city-operated shelters is $45 as of May 10, 1988. Residents of some private shelters which provide no meals or other basic services are eligible for a higher amount. Generally, shelter residents receive no shelter allowance. Shelter residents receiving public assistance and classified as employable will be referred to a workfare or Public Works Program (PWP). These policies, which may be subject to further modification, relate only to single adults. Family shelters are operated under different regulations. Persons in shelters for the homeless are also eligible for food stamps and Medicaid.

The First Visit. The first visit to an IM center is called a "prescreening." The IM worker will review the individual's circumstances and give a preliminary opinion regarding eligibility. An application form will be given to the guest, along with information about what documentation will be required at the application interview, which must take place no more than five working days later. A physical exam will be scheduled for some applicants to determine whether they should be classified employable and referred to a workfare or Public Works Program. If a person has a medical or psychiatric disability, an application for SSI or SSD should be made first, and proof of this pending application should be brought to the first visit.

Immediate Benefits. All applicants are screened for expedited food stamp benefits and if they are eligible, the expedited issue occurs within five calendar days. A person may be eligible for expedited food stamps if he or she has not received more than $150 in gross income in the month during which the application is made, and does not have liquid resources (savings, cash on hand) of more than $100. The applicant must have proof of identity for food stamps. Expedited food stamps are issued from the date they are requested until the end of the month.

If the guest is waiting for documents, it is possible to receive temporary assistance, referred to by the Department of Social Services as a single issue check. In addition, if the person has no money to buy food and food stamps are not immediately available, it is important to ask for this benefit. Single issue assistance is given as two $150 checks issued 15 days apart.

Required Documents. A Social Security card will be required for public assistance, but not for food stamps. If the person has forgotten his or her

number or lost the card, forms must be filed with the Social Security Administration to establish the number and receive a replacement card. It will be important to have *proof* of the pending application from the Social Security office. Other documents are required to establish the following information:

1. Identity. The following documents have been accepted (in many cases at least two forms of documentation will be required to verify identity):
   A letter from a shelter, soup kitchen, or agency, indicating that the person is known to them and for how long, is not as good as other forms of ID, but can be useful. Such a letter should be on letterhead.
   Hospital ID
   Driver's License
   Old welfare ID
   Social Security card
   Old Medicaid card
   Voter registration card
   U.S. Passport
   If a birth certificate is to be obtained, the Income Maintenance worker can request it after some advocacy, and the Department of Social Services absorbs the cost.

2. Sources of income and the amount.

3. Previous applications or receipt of public assistance.

4. Residence, if the person is living in a shelter. Here again, a notarized letter on letterhead stationery from someone at the shelter may be supplied.

5. Previous source of income. This category is generally difficult for homeless people, so as much documentation as possible should be gathered. For example, if the applicant had no income during a treatment program for drug or alcohol abuse, a letter from that program giving dates should be supplied.

The above list is not complete for all cases. Depending upon the individual's circumstances, other documents may be needed, such as proof of marriage or divorce. Even if the applicant is not able to provide all the information requested in five days, he or she should take whatever is available with the application (such as a copy of a letter requesting a birth certificate). It is important to keep the appointment.

After Applying. The Department of Social Services (DSS) must notify the applicant in writing of its decision within 30 days after the application. If the decision is negative, it will include information about the applicant's rights for

review at a fair hearing. If accepted, some delay may occur between notification of eligibility and the first payment. If this is a problem, contact the IM Center to ask for a single issue assistance.

Payment. New York City has changed from a system of mailed checks to a computerized method that distributes both cash assistance and food stamps on presentation of a plastic card. This system is called Electronic Payment Funds Transfer, or EPFT The recipient takes the magnetically coded card to a teller at a participating Manufacturers Hanover Trust bank or a check cashing outlet and slips the card into a computer terminal. The computer informs the teller how much money or how many food stamps to give to the card holder at that time. The card, which has a photograph and signature, is issued in the name of the adult authorized to receive payments. The IM center arranges for this photo identification. If the person is unable to redeem their benefits for some emergency reason, an authorization form may be obtained to allow a friend or relative to visit the bank and draw benefits for the person.

The following table shows the amount of public assistance benefits available as of January 1988.

PUBLIC ASSISTANCE BENEFITS LEVELS
(Effective January 1988)

Basic Allowance (excluding Rent):

Family Size	Per Month	Semi-Monthly
1	$ 94	$ 47
2	150	75
3	200	100
4	258	129
5	318	159
6	368	184
For each additional person	add $ 50	add $ 25

Home Energy Allowance

Family Size	Per Month	Semi-Monthly
1	$25.10	$12.55
2	39.50	19.75
3	53.00	26.50
4	68.70	34.35
5	84.70	42.35
6	97.20	48.60
For each additional person	add $12.50	add $ 6.25

Shelter With Heat

Family Size	Per Month	Semi-Monthly
1	$215	$107.50
2	250	125.00
3	286	143.00
4	312	156.00
5	337	168.50
6	349	174.50
7	403	201.50
8	421	210.50

N.Y.S. Employment Services. If a person is between 16 and 64, the IM Center will presume he or she is employable unless the person has a pending SSI application, is caring for children under the age of six, is ill, or is in a vocational training program. If considered employable, the person may be required to pick up the check at the offices of the New York State Employment Services. Several kinds of referrals may be made from the employment service:

Medical examinations

Job interviews

Office of Vocational Rehabilitation

Office of Treatment Management

Public Works Projects

Carfare will be paid to these appointments, and $2 a day for lunch for PWP participants, but it may be necessary to request the money.

Refusal to be placed in a PWP project without good cause may result in suspension or termination of benefits. If a person has a good cause, a fair hearing may be requested.

Other Grants. Special grants are available under certain unusual circumstances for the following:

- Moving and security deposit
- Storage fees following eviction or relocation
- Furniture grant
- Clothing (usually when clothing has been destroyed by fire)

Occupational training

Child care

Household repairs (generally to home owners only)

Fuel allowance (when landlord is not supposed to provide heat)

School transportation (If a child cannot travel alone, funds may be issued for the parent to accompany him or her to school.)

Restaurant allowance for families if their shelter situation provides neither meals nor cooking facilities

Apartment search for families

Maintenance. Both face-to-face recertification and requests for information by mail occur periodically. Failure to appear for the face-to-face meeting usually results in the person being dropped from Public Assistance programs. When a notice of determination is received, it is very important to act swiftly by filing for a fair hearing. Telephone 212-488-6550, or write to the N.Y.S. Department of Social Services, Fair Hearing Section, 40 North Pearl Street, Albany, NY 12243. An advocate's help in this event can be most helpful.

Other Benefits. Public assistance recipients are automatically eligible for Medicaid and food stamps.

Additional Resources

Public Assistance Sourcebook of Regulations (Free)
The official compilation of rules and regulations of the State of New York. Quarterly update containing all of the rules, regulations for public assistance, a description of the programs, eligibility, and budgeting, recipient/applicant rights, procedures for Emergency Assistance to Families. Write to:

N.Y.S. Department of Social Services
Division of Income Maintenance/W.M.S.
40 North Pearl Street
Albany, NY 12243
Phone: 800-342-3715

How to Get Public Assistance: A Handbook for Public Assistance Applicants and Recipients (1984). ($1.25 by mail or .50 if picked up at the office.)

A simple guide to all aspects of the welfare system. Contains state information and New York City-specific details.

South Brooklyn Legal Services
105 Court Street
Brooklyn, NY 11201
Phone: 718–855–8003

Manual for Welfare Advocates in New York City (1982)
A detailed guide designed for use by those working with applicants/recipients as well as applicants/recipients themselves. Contains New York State regulations, procedures, budget calculations, etc., covering welfare, food stamps, and Medicaid. Finer points specific to New York City. Expected to be available in 1987. Write to:

Community Action for Legal Services
335 Broadway, 5th Floor
New York, NY 10013
Phone: 212–431-7200

Supplemental Security Income (SSI)

SSI is a financial assistance program federally administered through the Social Security Administration. Actual funds for the program, however, are a combination of federal and state funds.

Eligibility. Persons 65 or over in financial need, or those of any age who are blind or disabled physically or mentally and have little or no income or assets are eligible. The Social Security Administration determines whether an applicant fits its definition of blindness and disability, as well as the amount of income and assets the person has.

Shelter Eligibility. Residents of city-operated shelters and overnight shelters sponsored by the Partnership for the Homeless can only receive a maximum of six months of checks in any nine-month period while residing in these shelters. The case will then be designated inactive, but not closed. Once the individual finds housing and notifies the Social Security Administration, checks will resume. Residents of private shelters not affiliated with the city are eligible to continue to receive SSI benefits without any interruptions.

Benefits. A single person with no other income living alone in 1988 receives $425.91 per month. A couple living by themselves is eligible for $624.53. Persons who live in an adult-care facility or in certified community residences

receive substantially more. However, the facility is paid most of the money with the beneficiary receiving between $66 and $86 a month for personal expenses. The recipient may earn a small amount of money without penalty.

Application. The applicant or advocate may start by telephoning the guest's local Social Security office listed below.

Manhattan	212-432-3232
Brooklyn	718-387-5700
Bronx	212-794-2000
Queens	718-526-8600
Staten Island	718-979-7760

The application is filled in by phone and then is mailed to the client to be signed and to collect the requested documents. The signed application and documents should be returned within 30 days. Required documents may include a birth certificate, bank books, medical history, or proof of disability.

Eligibility. A disabled person must be unable to engage in substantial gainful work because of a physical or mental condition that has lasted or is expected to last one year or longer or to result in death. Impairment must have lasted 12 months or longer and be so severe that it prevents the person from doing any work. The burden of proving the disability is on the claimant. An applicant will be considered disabled if he or she is diagnosed as suffering from a medical or mental condition included in Federal regulations referred to as listings. Often non-institutionalized persons who are mentally ill do not receive a swift, favorable decision through the first application. It is for this reason that mentally ill guests, in particular, when applying for SSI benefits will often require the careful investigations and follow-up made possible by a concerned advocate.

Help For the Advocate. Working with a guest to obtain SSI may be a rather complicated process, but it is not beyond the grasp of those who have the time and commitment. A number of organizations have prepared training and resource information about SSI for non-legal advocates. Contact local legal services organizations or those listed under resources after this section.

Denied Application. Typically, formal determinations occur two months or later after the date when the application is sent from the District Office to be

reviewed. If the application is denied, the applicant has 60 days from the initial determination to file for reconsideration, in the form of a written request. SSI reconsiderations rarely reverse initial decisions, but the next level of appeal—the hearing—often does reverse negative decisions. A great deal of advocacy is required for this appeal process. You may decide at this point that

the guest should be referred to a legal service or advocacy organization. After the claim is denied at the reconsideration level, the claimant has 60 days to file a request for hearing before an Administrative Law Judge. The request must be in writing and sent to the District Office. Acknowledgment of the request and a notice of the date of the hearing will be sent. Preparation for the hearing at this level may involve the guest working with a volunteer or worker and an advocate skilled in SSI hearings. If denied entitlements at this level, there are advanced steps that may be taken. We recommend that you seek the advice of advocates working with the guest or a legal organization.

Other Benefits. If the guest meets financial eligibility for SSI, food stamps will be issued after an application is made. An application for Medicaid is usually filled by the Social Security District Office once SSI benefits are awarded, and beneficiaries usually are eligible for coverage.

Resources

Several informative, up-to-date pamphlets and booklets may be obtained by calling 212-432-3232 or writing to:

The Department of Health and Human Services
Social Security Administration
District Office
333 Avenue X
Bronx, NY 11223

Social Security Disability

While SSI and SSD programs involve identical criteria for determining and documenting disability as well as an identical appeals process, there are some important differences between these two programs. The award of disability benefits (SSD) is based on documentation of a disabling condition as well as the person having worked for a sufficient period of covered employment determined, in part, by age of onset. An SSI recipient may never have worked or may have worked for only a brief time. While there are limits on income and assets for SSI eligibility, no such limits exist in determining eligibility for SSD, though having other types of benefits may offset the amount of SSD award. The amount of SSD award may be substantially higher than SSI because it is based on the person's lifetime average earning of covered employment, and is not affected by the person's living situation. For the same reasons, though, the amount awarded for SSD may be lower than SSI, so any guest who has a work history should apply for both simultaneously. Even if the guest is not sure about his or her work history, this information can be traced through a Social Security number. Households where all members receive SSI are eligible for food stamps.

Other Benefits. SSD recipients may not be eligible for food stamps or Medicaid if their SSD award and/or resources exceed eligibility limitations for these programs.

Food Stamps

In New York City, the Federal Food Stamps program is administered by the Department of Social Services of the Human Resources Administration (HRA-DSS). The information required by federal authorities for food stamp recipients is included in the application for public assistance. Most PA recipients receive food stamps. A person who applies for public assistance and is denied benefits will have a food stamp application pending, and a separate decision

will be reached on that eligibility. People who are working, as well as those receiving Veteran's Benefits, Unemployment Insurance, and so forth, may apply for food stamps. The same documentation is required as for public assistance.

Eligibility. The formula for food stamp eligibility is based not only on gross income, but also on net income level and size of the family. However, a number of facts are taken into account to establish net income, including expenses for dependent care. If unsure about a guest's ability to meet criteria, it is best to file an application. There is no requirement that food stamp recipients have a fixed residence, but they will need to verify city or county residence. Homeless applicants may establish an address through a community group providing services. It is not necessary to be a citizen to receive food stamps, but only certain categories of non-citizens are eligible. Documents will be examined. (See the Public Assistance section for the required documentation.)

Income and Resource Limitations. In 1988, a one-person household with a monthly income below $596 may be eligible. Monthly incomes below $804 for a couple and below $1,214 for a family of four are also within income limits. The non-exempt resource limits are $2,000 per household and $3,000 for households of one or more *if* one member is 60 years of age or older. Most personal property is excluded. Motor vehicles may be counted as a resource depending on value and use. In most cases, a car valued at less than $4,500 does not count toward the asset limit. The value of a dwelling is exempt, if it is the household's primary residence.

Receiving and Using Food Stamps. The EPFT card described in the Public Assistance section is also the method for obtaining food stamps.

Food stamps are presented to the cashier when paying for most food items in supermarkets and smaller neighborhood groceries or bodegas. Change is issued in food stamps if over a dollar or in regular coins if the amount is less than a dollar. Food stamps cannot be used for the purchase of non-food items such as cleaning materials, paper products, or soap. In addition, they cannot be used to purchase pet food, alcohol, or tobacco. Take-out food usually cannot be purchased with food stamps.

Food stamp recipients and their spouses who are over the age of 60 or receiving SSI or SSD can obtain a list of USDA authorized restaurants that accept Food Stamps in payment for meals by calling a toll-free number: 800-342-3009. These recipients must present their food stamp ID card stamped "restaurant-qualified" in order to use their coupons in restaurants. Food stamps can be used by senior citizens in some communal dining facilities. in group living situations like battered women's shelters, homeless shelters, drug and alcohol rehabilitation group homes, and housing for the mentally ill.

Loss of Benefits. If an application is denied, or benefits are reduced, the decision can be contested through the fair hearing procedure. Often just requesting the hearing will result in the settlement of the dispute. In general, the request for a fair hearing must be made within 90 days of the action being challenged. It may be requested by telephone by calling 212–488–6550 and/or writing to the Fair Hearing Section, New York State Department of Social Services, P.O. Box 1930, Albany, NY 12202. If the request is made within 10 days of the date of the notice of adverse action, the guest may request a continuation of the benefit.

If a recipient requests a fair hearing, it is not necessary to have a lawyer. But it is probably wise for an advocate who has experience with fair hearings to represent the recipient or advise the recipient and his or her representative regarding the conduct of the hearing.

Resources

Advocate's Guide to the Food Stamp Program in New York State (1987) and *Advocate's Guide to the Food Stamp Program in New York City* (1987). $6.00 per copy. Detailed guides to the law, procedures, eligibility, budgeting, etc., of the Food Stamp program. The New York State edition contains information pertinent to localities throughout the state. Write to:

Food Law Project/CALS
335 Broadway, 5th Floor
New York, NY 10013
Phone: 212–431–7200

FRAC's Guide to the Food Stamp Program (1983). $4.00 per copy + $1.50 postage and handling.
Details on Food Stamp Program operation in simple question-and-answer format. Write to:

FRAC/Food Research and Action Center
1319 F Street N.W., Suite 500
Washington, D.C. 20004
Attention: Publications
Phone: 202–393–5060

Food Stamp Source Book for Regulations (Free).
State certification manual containing all rules for the Food Stamp Program. Write to:

N.Y. State Department of Social Services
Linda Muncil, Director
Food Stamps Bureau
Division of Income Maintenance/Food Stamps
40 North Pearl Street, 7C
Albany, New York 12243

Medicaid

The Medical Assistance Program in New York State, also known as Medicaid, provides health care benefits on the basis of financial need.

Eligibility. People eligible for Medicaid include those receiving public assistance or Supplemental Security Income (SSI). Others may be eligible depending upon their income, assets, and medical expenses. People who believe they are disabled may be eligible if they meet the criteria for disability as provided under the Social Security Act depending upon their income, assets, and medical expenses. Certain people who received Social Security benefits and SSI at the same time, and now no longer receive SSI may be eligible.

The following table shows income levels used in determining benefits.

Medicaid Income and Resource Levels (Effective January 1, 1988)

Family Size	Annual Net Income	Monthly Net Income	Resources
1	$5,200	$434	$3,100
2	7,500	625	4,750
3	7,600	634	5,300
4	7,700	642	5,850
5	7,800	650	5,900
6	7,900	659	5,950

Income exemptions and resources include a home, car, life insurance, and personal property up to specific limits.

Application. Public assistance and SSI/SSD recipients have Medicaid applications processed at the same time as their other benefit forms. The general information telephone number for Medicaid in New York City is 212-594-3050.

Coverage. Medicaid pays the medical bills of *eligible* individuals and families who cannot afford medical care. Listed below are medical services that can be paid by Medicaid:

- hospital inpatient services
- hospital outpatient services
- laboratory test x-rays
- physician's services
- skilled nursing home services
- child health assurance program
- family planning services

Medicaid also pays for home health care services, drugs, sickroom supplies, eyeglasses, prosthetic appliances, transportation, and personal care services. Some of these services require prior approval for payment to be made by the program.

Unlike Medicare, which is an insurance program for almost everybody 65 or older, regardless of income, Medicaid is an *assistance* program for certain groups of needy and low-income persons. Individuals covered by Medicare and other third-party health insurance may still be eligible for Medicaid.

Shelter Eligibility. Residents of city-operated shelters and other shelter programs are eligible for Medicaid. As of this printing, residents of city-operated shelters for single adults may apply at one of three designated Medicaid centers. They are the Main Center in Manhattan, the Melrose Center in the Bronx, and the Livingston Center in Brooklyn. Residents of the Partnership for the Homeless affiliated shelters can receive assistance applying for Medicaid from caseworkers at their screening sites. Eligible shelter residents will be issued a Medicaid card (known as MA ID cards) they can present to health care providers to verify they are in receipt of benefits.

Other Situations. Hospital emergency rooms will assist patients with application for Medicaid, but should treat them regardless of coverage. A person does not need to have a Medicaid card to get treatment in an emergency room. However, because not all physicians accept Medicaid, persons having Medicaid coverage should always inquire if a specific physician will accept Medicaid for routine care.

WHEN GUESTS DON'T WANT TO APPLY FOR BENEFITS

Some guests will be reluctant for a number of reasons to apply for benefits to which they are legally entitled. These may include a past experience that was time consuming, aggravating, and resulted in being found ineligible or being dropped from an entitlement program. They may have been told they were not eligible and accepted this denial rather than filing a written application. (The guest should be reminded that he or she has the right to file an application, no matter what he or she has been told.)

Another reason for not wanting to apply may be that the individual has been sanctioned (denied benefits) for 30 days for failing to comply with employment requirements. For instance, a guest may have gotten an appointment notice for PWP (Public Works Program) too late and then was sanctioned for 30 days. Some guests may be reluctant to apply after previously failing to secure required documentation which you may be able to assist in obtaining.

Anyone who is in this country illegally may strongly resist applying without giving a clear reason because they fear their illegal status will be reported to the authorities. If a person is in this country illegally there is a possibility that a government agency will report their status to the Immigration and Naturalization Service (INS). Even though the law states that any individual can apply for entitlements, in general, people who are not citizens of this country are ineligible for public assistance benefits. It is strongly recommended that they be referred to organizations specializing in immigration rights for legal advice before applying for any entitlement. One such organization is:

Center for Immigrants' Rights
48 Saint Marks Place
New York, N.Y. 10003
212-505-6890

Some guests resist because the application process forces them to confront their inability to work. Others have a strong sense of pride and do not want to "take a handout." Still others resent having to reveal their private lives in the necessary forms and interviews.

When working with a guest who does not want to apply for benefits, begin by talking to the guest about his or her feelings. Let the guest know that entitlements are a right under the law. Listen to what the person is saying. In all likelihood, the guest will have useful information about his or her past experiences.

Before encouraging a guest to apply for benefits, it is important to clarify certain rules and regulations with which the person must comply if benefits are to begin and continue. Guests should not be encouraged to initiate the effort if such conditions are unacceptable to them.

ENTITLEMENT ADVOCACY RESOURCES

The Legal Action Center provides information and assistance to organizations in New York City that work directly with homeless people. Formal seminars are given and staff members are available for advice and guidance.

Legal Action Center for the Homeless
P.O. Box 1161
New York, NY 10035
212-529-4240

References

Government Money for Everyday People—A Guide to Income Support Programs (1982). A comprehensive guide to state and federal programs for families and individuals. 30 programs are detailed. $10.00, payable to Adelphi University School of Social Work. Write to:

Adelphi University Press
South Avenue
Garden City, NY 11530
516-294-8700

Veteran's Benefits and Military Discharge Upgrading: A Manual for Mental Health Advocates in New York City. June 1983. This is a very comprehensive general reference. Write to:

M.F.Y. Legal Services, Inc.
Community Support Systems Programs
41 Avenue A
New York, NY 10019

The People's Guide to Fair Hearings in New York City. February 1985. Explanation of the fair-hearing process in New York City in simple terms. (Free.) Write to:

The Legal Aid Society
Administrative Law Unit
Community Advocate Project
11 Park Place—5th Floor
New York, NY 10007

Where to Write for Vital Records

New York City Department of Health
Bureau of Vital Statistics
125 Worth Street
New York, NY 10013

The New York City Department of Health maintains records for people born in New York City. A birth certificate costs $5.00. Other documents vary in cost.

New York State Department of Health
Vital Records
Empire State Plaza—Tower Building
Albany, NY 12237
517-474-3077 or 3038

This department maintains records of births, deaths, marriages, and divorces in New York State.

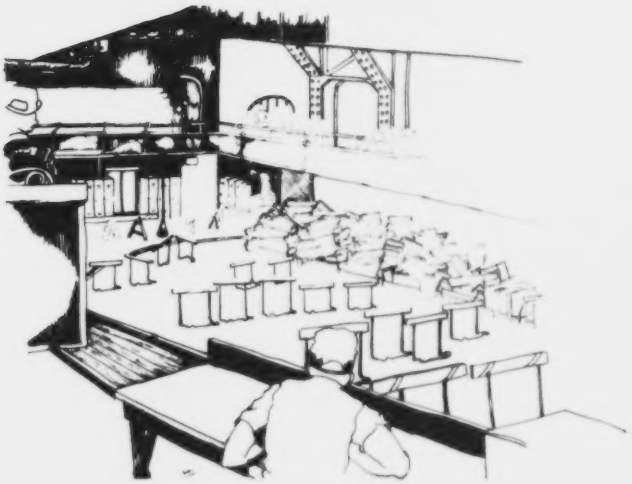
SUMMARY

As you can see, the route to receiving entitlements is sometimes a complicated path. Be sure that you have the time and energy to devote to helping a guest with these matters before you begin. Remember that rules and regulations are continually being updated and revised. When issues become complex or confusing, make sure you consult with your coordinator or an outside advocate.

The final chapter, Shelter Administration, follows. It is addressed to volunteers or staff members who wish to become more involved with running a shelter as well as those already doing so. If you are not interested in helping to manage the shelter, you may wish to skip over it. Otherwise, look it over and see if you find any suggestions that might be helpful for your shelter's administration.

Chapter 9

Shelter Administration



I barely have a chance to think. Just keeping this place open, catching problems before they blow up, helping everybody cope with crisis after crisis. It takes all the time and energy I have to give and then some. There's just so much a shelter can do.

—coordinator of a church shelter

When most overnight shelters in churches and voluntary agencies first opened their doors to homeless men, women, and children, volunteers and leaders understood their activities to be a response to the "temporary crisis" of homelessness in New York City and New York State.

Local organizations were adapted or new ones formed to mobilize resources to cope with the crisis. Leaders of local sheltering efforts attained the role of coordinator based upon their immediate availability, willingness to donate time and energy, and capacity to exercise leadership in a crisis atmosphere. Basically, a willingness to do the work determined who administered most new shelters. The demands of crisis management largely shaped the structure and methods used by a coordinator to run a shelter.

Today, however, few perceive homelessness to be a temporary crisis. The need for shelter, both overnight and permanent, is understood to be long-term and the crisis appears to be a chronic problem with a lengthy history and an indeterminate future. In this context, shelters and their sponsoring agencies are

formally and informally re-examining how to plan and manage their programs to endure and, in some cases, to expand. Consequently, many coordinators are seeking to enhance their administrative skills and to learn methods for the management of a shelter as a stable organization with the capacity to manage ongoing changes. This chapter is intended to help staff develop their administrative skills and strengthen their organization's capacity to manage its most important resources—volunteers. It will be of greatest relevance to coordinators, directors, salaried administrative staff, and church leaders who are responsible for the administration and/or governance of a program serving the homeless.

YOUR PROGRAM

Due to variations in resources, physical space, the needs and interests of guests and workers, and many other factors, there is no single ideal model or administrative structure for a shelter program. Central to the successful operation of any organization, however, is an understanding of its basic aims and approach. It is often difficult to state, in a few words, the purpose and broad objectives—the mission—of the organization in which you are working. It is particularly important for a coordinator or other administrator to be able to define the mission of his or her shelter and to make this "mission statement" available to all of those who play a role in making the shelter work.

It is only after a program specifies its mission that it is able to develop a set of policies, procedures, and rules that can effectively guide the activities of program staff. In a sense, the program's mission answers the question: "Just what is it that we are trying to accomplish?" Issues such as emphasis on temporary versus permanent housing, women versus men, individuals versus families, and night services as opposed to 24-hour services are implicit in an organization's statement of mission.

To combine the goals and mission of the shelter with the goals and wishes of the volunteers to serve a portion of the homeless population effectively is a tall order for the shelter coordinator. The task begins with the refinement of a clear statement of purpose and the elaboration of that statement into a coherent set of policies, procedures, and rules that will serve to guide the efforts of program volunteers in carrying out the mission. With practice and the opportunity to develop skills and knowledge, the coordinator can choose and implement an administrative approach that works best for the particular shelter and the community it serves.

THE COORDINATOR'S ROLE

The role of coordinator in a volunteer-operated shelter is a difficult one, in part because he or she is responsible for so many different functions. The following list covers many of the functions that coordinators commonly perform.

- Obtaining space, materials, and regular supplies.
- Recruiting, orienting, training, and supervising volunteers
- Scheduling volunteers or staff
- Securing adequate resources through fundraising
- Maintaining the shelter budget (including necessary paperwork and record keeping)
- Serving as liaison with other organizations and agencies
- Planning special programs (such as holiday meals or events)
- Managing crises and unforeseen problems
- Counseling the most troubled or demanding guests
- Maintaining the mission, goals, and climate of the shelter
- Helping volunteers and staff to understand their respective roles and resolving conflicts when they occur
- Representing the interests of the shelter to the sponsoring organization and *vice versa*.

It can be a useful exercise to rate the relative importance of each of these functions and estimate the amount of time actually spent on each. It is quite likely that the most important functions will not be the ones that consume most of the coordinator's time. For instance, recruiting and nurturing capable volunteers may be one of the most important activities for maintaining the program. Yet upon reflection, the coordinator may discover that there is little time for this important function after dealing with the paperwork and the daily crises.

An important task, then, is to set priorities and balance these activities to best meet the goals of the program while remaining true to the overall mission of the organization. When the coordinator sees that he or she is spending disproportionate time on activities of secondary importance at the expense of key functions, it is time to make some adjustments in his or her work schedule. Doing this well is the mark of an effective administrator.

Being a Good Administrator

Administering any organization is a challenging task. This task can be even more difficult in an informal setting like a shelter that relies heavily on part-time, non-paid staff. The following list describes characteristics of effective administrators in a variety of settings:

- Sets, or guides in the setting of, clear goals that are reachable.
- Knows when and how to delegate authority and responsibility.
- Gives support, critical feedback, and recognition to individuals and teams.
- Builds cooperation and cohesiveness among co-workers.
- Buffers volunteers from problems for which they are not responsible.
- Provides involvement whenever possible to all who will be affected by a decision.
- Allows regular and consistent opportunity for communication, serving as an information link between people who don't see each other.
- Encourages volunteers to learn from what they are doing to achieve personal growth in their skills and capacities.
- Develops trust through organizational predictability and consistency.
- Develops policies, procedures, and rules that aid in the effective operation of the organization.

POLICIES, PROCEDURES, AND RULES

In voluntary shelters, one common problem is a lack of clarification of both policies and procedures. Given the haste to set up programs answering an immediate need, there is often little opportunity to develop explicit policies and procedures. In some instances, volunteers are wary of instituting policies and procedures, fearing that the friendly informal atmosphere of their shelter will be lost.

The lack of policies and procedures, however, inevitably leads to difficulties. These run the gamut from individual volunteers making important decisions that run contrary to the wishes of the designated decision-makers to the pervasive assumption that "someone else" is taking care of a particular problem, when in fact, nothing is being done.

Policies establish an organization's boundaries for decision-making in a particular area by describing the judgment, philosophy, and guiding principles of the policy maker(s). Procedures are a step-by-step guide for action. They describe the way in which policies are to be implemented and specific tasks are carried out. Rules are rigid statements of what should and should not be done in particular situations.

It will be helpful to review some of your shelter's policies and rules in order to explore how your program is working. Ask yourself:

1. Do we have policies on all the major issues necessary to guide the program? Policies are often necessary to decide:
   Who does the program serve?
   What services are provided and not provided?
   What is acceptable and unacceptable conduct for guests and staff?
   What is the criteria for volunteer recruitment?

2. Are our policies clear and understood by all?

3. Do we have procedures to guide staff in implementing all policies?

4. Are procedures sufficiently clear so that a new volunteer can be expected to know and implement them shortly after beginning with the shelter?

5. How do guests and volunteers clarify questions about shelter policy?

6. Do we have sufficient rules to enable volunteers to direct guests in conforming to the policies of the shelter?

7. Is there evidence that guests or volunteers are unfamiliar with shelter policy, procedures, and/or rules?

The following is an example of one set of policy, procedure, and rules.

Policy: The shelter discourages guests from alcohol abuse and will not allow its use on or near the shelter premises.

Rule: Guests are not allowed to consume alcohol within or in areas adjacent to the shelter. Anyone doing so will not be allowed to spend the night in the shelter.

Procedure: If any guest is observed to be drinking in or near the shelter, he or she should be informed of the policy and that they have the choice of giving a volunteer the alcohol for safe disposal or leaving the shelter for

the night. If the guest resists, he or she should be reminded that the shelter's policy has been made clear to all guests and that he or she does have a choice in the matter. If the guest resists further, the volunteer should seek the assistance of another and use the procedures for conflict resolution suggested in Chapter 6.

Shelter administrators are likely to have their greatest impact through clear policies that provide general guidance and direction. Step-by-step procedures, on the other hand, are best reserved for particularly complex administrative problems, or issues that regularly generate tension and conflict between guests, or with and among volunteers. The development of a document summarizing shelter policies and guidelines for volunteer conduct is a wise investment of time for all shelter coordinators. In addition, meetings of all shelter volunteers at least several times a year will ensure that policies are reviewed and allows a format for suggesting changes.

LEADERSHIP PATTERNS

Particularly in the unpredictable world of running a shelter, the need to make choices and decisions affecting the organization is an ongoing one. The decision-making process varies widely between different organizations. Particular forms of decision-making generally flow from leadership patterns found in different settings.

Leadership patterns are sometimes seen as comprising points on a continuum ranging from authoritarian to *laissez-faire*, with a delegated responsibility style falling somewhere in between these poles.

Authoritarian styles generally locate all determination of policy with the leader. Work tasks are devised and dictated by the leader to his or her subordinates with heavy reliance on rules.

Delegated styles specify areas of responsibility in which staff and volunteers are encouraged to use their own judgment in making decisions and running the program. They depend upon the articulation of clear policies by the coordinator or program leader that guide staff decision-making in specific instances. Delegation encourages group discussion and decisions on policies with assistance by the leader. Through this discussion, staff develop a perspective on the organization's goals and priorities that serve as further guides to action.

Laissez-faire styles downplay the role of the leader and allow complete freedom for group or individual decisions to emerge. Work assignments may be left open or left to staff to define and implement on their own.

It has been demonstrated that the effectiveness of particular styles depends upon the nature of the organization being managed. For instance, authoritarian styles, which rely heavily on rules and centralized authority, seem to work best

in settings whose functions are highly predictable and routinized, such as assembly-line factories. In shelter settings and other small, human-service organizations, however, a more flexible delegated style will usually be more effective. This is true for several reasons. For one, volunteers need to feel like part of a team contributing toward important ends. For another, shelters are unpredictable places. Problems and issues that have not been anticipated often arise, leaving workers without relevant rules or procedures to follow. Since the coordinator or supervisor may very well be absent, it is imperative that staff feel able to respond appropriately to the situation based upon their own judgment.

On the other hand, a highly unstructured or *laissez-faire* arrangement may lead to problems, such as staff working at cross purposes and a lack of accountability. A high degree of interpersonal conflict may result when explicit responsibilities and lines of authority are not spelled out.

Working with Volunteers

Most programs serving the homeless, whether staffed mostly by paid employees or exclusively by volunteers, must respond to the question of how to integrate and utilize volunteer help. Some programs actively recruit volunteers; others are flooded with volunteers but have only a limited number and range of activities to offer. Still others find that volunteers and donations are not put to effective use in their organization. Volunteers sometimes need

to shop around for the right program. In turn, programs needing volunteers must design specific roles with an understanding of the nature of volunteerism.

In reality, there may be little difference between employees and volunteers: they may or may not have any relevant experience, and both need to be trained, supervised, and recognized for their contribution. Losing a good employee and losing a good volunteer may be equally detrimental to a program. Because volunteers are unsalaried, though, the motivation to participate consistently with a program is dependent entirely upon factors other than a paycheck. Keeping a shelter staffed with enthusiastic, effective volunteers takes time, skill, planning, and energy. It is unrealistic to think that volunteers will stay with a program just because the work is important and very much needed. Giving attention to volunteers' feelings and expectations can make the difference between having or not having enough staff to keep a voluntary shelter in operation.

Why Volunteers Continue or Expand Their Commitment

Volunteers continue with a program because they have a sense of making a difference in the lives of others and a feeling that they are appreciated. The perception of personal improvement, spiritual growth, and/or learning new skills, and a sense of belonging also encourage volunteers. Emotional support from others, including guests, families, and the media may encourage a volunteer to expand his or her commit ment. If the program adjusts to fit their schedules, to the maximum degree possible, volunteers are likely to continue. Finally, an opportunity to participate in problem-solving and decision-making can boost volunteer morale.

Why Volunteers Drop Out

Volunteers drop out when there is a gap between expectations and the reality of the work. A lack of emotional support and appreciation discourages volunteers as well as the lack of relationships with full-time staff or persons regularly in charge. The devaluation of his or her commitment by others may affect a volunteer's commitment. The general morale and working conditions in the shelter may make the volunteer feel overwhelmed. The lack of clear steps to fulfill the stated goals of the organization creates confusion and contributes to volunteers dropping out.

In addition to the above, a volunteer may be genuinely interested in participating, but be simply unsuited for the role your program offers. For instance, a volunteer may feel uncomfortable around groups of people in the shelter setting. That same person may be much more effective doing office work or coordinating food deliveries. It is helpful to know other programs serving homeless people in your area. Volunteers are a valuable resource sometimes shared between agencies.

Recruitment

Matching individual expectations to the reality of the job is paramount. Some shelters distinguish their recruiting techniques between "door openers" (encouraging guilt feelings, social pressure, or using the influence of the clergy) and obtaining "solid commitments" through means such as trial periods for new volunteers, where a commitment is only expected after an opportunity for direct experience in the shelter or an open house where interested persons can learn how the shelter operates. "Telling the story of the shelter" in the local press or by requesting a spot on the agendas of neighborhood organizations is a valuable technique. Pairing new people with more experienced volunteers encourages commitment. Using the social ties of existing volunteers to reach out to new people is effective. Establishing participatory volunteer orientation programs that incorporate new volunteers into the shelter system will help you get the solid commitment you need.

Most volunteers are in search of a structure that is:

- Not bureaucratic
- Does not have endless meetings
- Effective in making and implementing decisions
- Builds a sense of community
- Gives direction to the sheltering effort

COMMUNICATION AND STAFF CONFLICT

Communication and feedback are essential for volunteers and may be rather difficult to maintain in programs where they do not work at the same time or on the same night. Ways to provide communication among volunteers might include monthly community meetings; open-ended reminders and follow-up telephone calls; a formal ceremony of appreciation; church bulletins or pulpit announcements; a time for coordinators and volunteers to review the work; training sessions; a newsletter; and coordinators serving as the link between volunteers who work different nights.

Effective communication between staff is crucial to the smooth operation of any organization. In programs that address needs as profound as those of the homeless with the minimal resources typical of shelter operations, staff conflict is often common. Conflict is frequently caused by the clash of demands for very limited resources. It is also caused by insufficient communication within a staff or between the leader and his or her staff. Conflict can also result when

staff are not clear on their roles, are not familiar with the policies of the program, or lack knowledge of program rules and procedures.

Unfortunately, conflict feeds upon itself. As workers put more energy into disagreements, less time is available to devote to the shelter functioning. High levels of conflict tend to lead to workers replacing their investment in the overall purpose of the program with the specifics of their conflicts. Continued conflict within programs leads to low morale and often results in high staff turnover, which decreases the organization's efficiency considerably.

Conflict is not always bad. It is, in itself, a valuable form of communication that may lead to positive outcomes. A moderate amount of conflict can encourage a certain constructive competition, motivating individuals to develop more innovative and workable ideas for shelter functioning. A diversity of viewpoints on any given issue can greatly improve the quality of the final decision. A program comprised of people from a variety of backgrounds—racial, class, age, gender, sexual preference, and so forth—will have much more room for disagreements than a homogeneous one, but it will bring a greater richness and balance into the program's policies.

Discussion of conflict can be an invaluable tool for learning about one's own style, beliefs, and behavior and the effects upon co-workers. The need to communicate one's position clearly to others encourages an understanding of the dynamics of the conflict and the group.

How to Resolve Intra-Staff Conflicts

Create Superordinate Goals. These are goals that transcend the conflict specifics, have the commitment of both parties, and require cooperation to be accomplished.

Appeal to a Higher Authority Person. This is a fairly effective *temporary* method. But the disadvantage is that the basic issues are not addressed, and usually the opponents are put into a win/lose situation. The losing party may feel compelled to initiate another provocation to even the score.

Confront the Issue Through Problem Solving. This is based on the idea that conflict lies in the inability of various solutions to meet differing needs. Issues are confronted by having people clarify their differing needs and methods designed to meet those needs, identify and highlight their common concerns and points of agreement, and develop alternate solutions which meet the needs of both parties.

Although it is time-consuming, this method's effectiveness lies in addressing causes and basic issues, attempting to reach solutions that are mutually acceptable to both parties.

Compromise. This is the form of conflict management most commonly practiced, perhaps because it is a temporary solution that must be used over and over. Typically, two parties start as adversaries, then settle on a point somewhere in between. Both parties are required to give up something but not everything, and the agreement is usually reluctant. Besides being a temporary fix, another drawback is that this method addresses outcome rather than root causes. As such, the conflict issue can reappear.

Expand Organizational Resources. This is especially useful for conflicts over roles within the organization. For instance, if two volunteers want to be a coordinator, a solution might be that one coordinates community resources relationships while the other could manage internal functions of the shelter.

BURNOUT

Burnout was first described in professional literature as an explanation of the high drop-out rate in volunteer-run alternative services, such as free clinics or crisis centers. The term has come to refer to failed expectations, exhaustion, the withdrawal of energy and commitment, and progressive stages of disillusionment in the meaning of the work.

Burnout is somewhat of a catch-all term with widely varying meaning as to what it is, its causes, and how an organization ought to respond. Factors contributing to burnout include structural characteristics often found in shelter settings. Among these are:

- The lack of organizational, community, and family support for the shelter work.
- Poorly defined roles and ambiguity.
- The chronic shortage of money, space, and supplies to do the job adequately.
- An inadequate pool of volunteers and the resulting overwork of those available.
- The unpredictability of the work situation because of the high turnover rate of volunteers and the constant need to begin again with a new person.

Volunteers' attitudes and beliefs may also contribute to burnout. These include:

- A powerful belief, sometimes encouraged by shelter leaders, is that no matter how much one does or gives, the needs of homeless people are so much greater.

- Overidentification with the work of the shelter, leading to an inability to say no.
- Low self-esteem, which drives a person to overwork in order to achieve a sense of keeping up with others.
- The conviction that one must suffer to serve.

How To Respond To Signs of Burnout

The general steps suggested below will vary in their applicability according to organization and the specific stage of the burnout process of individual volunteers or coordinators, but serve as a general guide:

1. Encourage the person to take responsibility for his or her feelings and the choice of what he or she wants to do.

2. Identify specific structural changes that shelter leadership might implement to prevent burnout.

3. Make note of feelings that go beyond the person's work or realm of influence; then, assist the person in learning to let go of them.

4. Clarify volunteer roles and shelter policy and procedure.

5. Establish realistic personal goals that are obtainable within the limits of the position.

6. Create opportunities for support from co-workers.

7. Realistically assess the givens or factors in the position unlikely to change. Review what can be done, and is being done, to help the guests your program aims to serve.

TRAINING

Shelter Coordinator as Training Leader

This section is written for the coordinator or senior volunteer who trains and orients the program's volunteers. A training leader does not need to be a professional trainer or an expert in all areas to develop skills and pass along information to others.

The coordinator should identify needs, organize resources, and facilitate the learning process. He or she should understand that volunteers and staff want to become more informed and have the opportunity to share their experiences.

Training can be both formal and informal. Informal training occurs when a new volunteer is placed with an experienced one to absorb the methods and routines. Formal training is generally conducted in a meeting or workshop setting.

Structuring the Learning Situation

Because participants are adult volunteers and the training agenda is specific, the activity will be quite different from a classroom situation. Research and experience have shown that adults learn differently than children. Adults have much more personal experience to incorporate into their learning and need to be more active and directive in their learning experiences. Here are some guidelines for setting up a structured learning situation in a shelter program.

Identify the Training Group. Will you require all volunteers and/or staff to participate, or will it be optional? Those who do not feel the need for additional learning are not likely to benefit. In addition, it is often preferable for volunteers to have some beginning experience with the program before being presented with a formal training setting.

Assess Training Needs. Staff and volunteers should be polled, through individual conversation, group meetings, or written questionnaires. The preference of the majority should guide the agenda.

Structure Training. After-work hours are generally the best time for training. Ideally the meeting is done in a quiet, uninterrupted place. This sort of session requires planning—reserving a room, making sure there are enough chairs, setting an agenda, etc. Have a plan for the topic and how it will be structured. Examples of structuring by the training coordinator are:

Bringing in an outside expert.

Finding and making copies of written materials that closely match the shelter's problems.

Leading a discussion with the focus on solving one problem.

Challenging the group to choose among priorities and how to use their time.

Listing and identifying strengths, often unacknowledged, within the group.

Stay within the design of the meeting. Give time and assistance apart from the group when someone has a problem that is either unique or disruptive to the flow of the group.

Some Principles for Effective Training Sessions

Training must focus on the felt needs of participants. They *must* have a sense of needing the information presented. Learning activities should be problem-focused. Adults are particularly motivated to solve problems.

The training process must be active. It's much more effective for adults to gain insight through analysis of a training experience than to be "told" these insights in a lecture format. Opportunities for practice and experience should be provided.

The learning climate—the physical and emotional setting—should be comfortable and allow the participants to feel sufficiently free of criticism or group pressure to risk making mistakes. The trainer should provide clear and consistent feedback to participants. Allow the participants to review and analyze the learning experience.

Training and problem-solving discussions are invaluable components of any volunteer program, not just as an orientation for new volunteers, but also as an ongoing means for shelter workers to expand their skills and insights about this very valuable work.

SUMMARY

We hope that this book has been useful for you, whatever your role is in a shelter. As has been stated before, temporary shelters are, at best, a limited response to the problem of homelessness in our society. Until decent, affordable housing is available, however, safe temporary shelters are a necessity.

Following is an appendix listing publications that will provide a broader understanding of the scope of homelessness, housing, service issues, and government responses to this complex issue.

Appendix

Additional Resources

Bratt, R., et al., eds. *Critical Perspectives on Housing.* Philadelphia: Temple University Press, 1986.

Hope, M. and Young, J. *The Faces of Homelessness.* Lexington, MA: D.C. Heath, 1986.

Hopper, K. and Hamberg, J. *The Making of America's Homeless: From Skid Row to New Poor, 1945–1984.* New York: Community Service Society, 1984.

Erickson, J. and Wilhelm, C., eds. *Housing the Homeless.* New Brunswick: Rutgers University, 1986.

Lamb, H. Richard, ed. *The Homeless Mentally Ill.* Washington, D.C.: American Psychiatric Association, 1984.

New York State Department of Social Services. *Homelessness in New York State.* Albany: New York State Department of Social Services, 1984.

United States General Accounting Office. *Homelessness: A Complex Problem and the Federal Response.* Washington, D.C.: GAO/HRD-85-40, 1985.

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